## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q

1700

			C	ertificate of	f Death		Reg. No.	17001	
	1. Decedent's Nema (First, Middle, La	st)				2. Date of De	ath	3. Time of Deeth	
Physician /Medical	Kathleen Cla	ire Aspl	en			Month	17, 1999	8:46 P.M	
Examiner	4a Facility Name (If not institution, giv	a street and number)			4b. City, Town, or	Location of Death	4c. County	of Deeth	
	Anne Arundel M	edical Cen	ter		Annapo	olis	Anne	Arundel	
Funeral	5. Social Security Number 6. S		(In yrs. last birthda			8. Date of Birt	h Voesl	9. Birthplaca (State or Foreign	
Director	220-04-6922 Usual Residence of Decedent	I□M 2ÅF	32 Yrs.	Months Day	s Hours Min.	Feb. 2	5, 1967	9. Birthplaca (State or Foreign Massachusetts	
Pun Bu	10e. State 10b. County	- 1	10c. City, Town or	Location				10d. Inside City Limit	
with the Maryland a or 28a-f show Libe notified at Director	Md. Anne A	runde1	Arno1	d				1 ☐ Yes 2 ☑ N	
noting	10e. Street and Number	r dride i	7111101	10f. Zip Code	Value of the last		10g. Citizen of V	Vhat Country?	
The other	439 Manor Road			210	012		U.S.	Α.	
hours after death with the Maryla tunif, or flams 23e or 28e-f sho at Examiner must be notified at 3d by Funeral Director	11. Meritel Status  1 Nevar Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N if Yes, Give Yeer or Dates:	Ever in U,S. 13	3. Wes Decedent of If Yes, specify Cu 1 Yes 2 No	Hispanic Origin? (S ban, Mexican, Puerl Specify:	pecify Yes or No to Rican, etc.)	- 14. Race Blec Specify	e - American Indien, ck, Whita, etc.	
and a part of the	15. Decedent's Ed	ducation	16a. Dec	edent's Usuel Occ	upation		16b. Kind of Bu	usinass/Industry	
ygiere. Ygiere. Ygiere. Ygiere. Ygiere. Ygiere. Ygiere. Ygiere. Ygiere.	(Specify only highest gra Elementery/Secondery (0-12) 12th	College (1-4or 5	(Gir	re kind of work don DO NOT use retir Unemplo	e during most of wor ed)	rking		abled	
	17. Father's Neme (First, Middle, Last)	)			1	na (First, Middle,	Maiden Sumem	e)	
No De 1	Charles Henry	Asp1en			Barbara	Lois	Duva11		
2 shou and M is man aumen	19e. Informent's Neme/Reletionship (	Type, Print)	19b. Ma	iling Address (Street	et and Number or Ru	ıral Route Numbe	er, City or Town,	Stete, Zip Code)	
2442	Barbara L. Asple	n ( Mother	) 439	Manor Ro	ad Arnold	d. Marvl	and 2101	2	
~ 1 2 5	20e. Method of Disposition	ii ( Modici	20b. Plece of Dis	position (Name of		Dete		City or Town, State	
ages ant of the M	1 \( \Burial \) 2 \( \text{Cremation} \) 3 \( \text{4} \( \text{Donation} \) 5 \( \text{Other} \) Other (Specif			emetory or other pl Hill Ceme		5/20/99	Baltimor	re, Maryland	
THE P			7			,, = 0, = 0		-, <u>,</u>	
Dap may amy	21. Signeture of Funeral Service Licensee  22. Name and Address of Facility  MCCully-Polyniak Funeral Home P.A.  237 F. Patapsco Avenue Baltimore, Maryland 212  Approximate Intervel Between Consett endowed and the shock, or heart feiture. List only one cause on each line.								
	Kanul C	1 / /01/	2	37 F Pat	tanson Ave	anue Ral	timore N	Maryland 2122	
	23a. Part1. Enter the disease, or com	plications that caused	tha death. Do not e	nter the mode of d	ing, such es cardiad	or respiretory a	rrest,	Approximete	
Physician	SHOCK, OF REST TENDED. LIST ONLY	Ole Cause Ol each III		,				Onset end Death	
/Medical	Immediate Cause (Final	6	onother &	piling.				4 days	
Examiner	disease or condition resulting in deeth)	a. //	904110 19	CIIUIV				- Tuuyo	
<u> </u>		n	another o	VI 10: ml OCD					
m in min		b. //C	ALCOLLO C	verque				1	
e attending physician and od or use as the burial-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury c.								
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physicia s the bu									
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attendi for usa									
54 %	Pert II. Other significant conditions of	ontributing to death bu	t not resulting in the	underlying cause of	jiven in Pert I.	23b. Dld 1	obacco usa cor	ntribute to the cause of dea	
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D 20 8									
sate has been sign, page 2 should be							en autopsy med?	24b. Wera autopsy finding available prior to	
has by							/	completion of cause of death?	
page Com						101	res 20 No	1 ☐ Yes 2 DNo	
certificata rector, pag	25. Was case referred to medical	/			26. Place of Dec	eth (Check only o			
. = 0	exammer? 1 ☑ Yes 2 ☐ No	Hospitel: 1 V Inpatier	nt 2 ER/Outpati	ent 3 DOA	ther _	lome 5 Resid		er (Snecity)	
rethis and T.T.	27. Menner of Death	28a. Dete of Injury (Month, Day					now injury occurr		
After fune	1 □ Natural 5 □ Pending 2 □ Accident investigation		Year) Injury		ork? ☐Yes 2☐No	namoto	+ nipm	nca	
Attending ar death. ector: After by the fune tiffication	3 Suicide 6 □ Could not be	ry - At home farm	UUN		28f. Location (5	Street and Numb	er or Rural Boute Number		
tal or Attending P rs after death. el Director: After t ed in by the funers Certification:	4 Homicide determined	building, etc	e. Place of Infury - Al home, farm, street, fectory, office  28f. Location (Street and Numbuilding, etc. (Specify)  1707  1707  1707					al Amal	
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within 24 hours after within 24 hours after To the Function Directory completely filled in b Medical Certifi	29e. Certifier 1 Ofrtifying Ph (Check only 2 Medical Exam	ysician: To the best of niner: On the besis of	examinetion end/or	am occurred at the investigation, in my	time, date and place opinion, deeth occu	red et the time,	cause(s) end me date end place, a	nnar as stated. and due to the ceuse(s)	
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200	29b. Signature and titla of certifier	XV (Ca)		29c. Lice	nse number		290. Date signed	d (Month, Day, Year)	
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	30. Nema and address of payson who	completed cause of de	eth (Item 23a) (Type	e, Print)			J	1	
	2414 Hight	op, Ct.	Crotton	(4)	41114				
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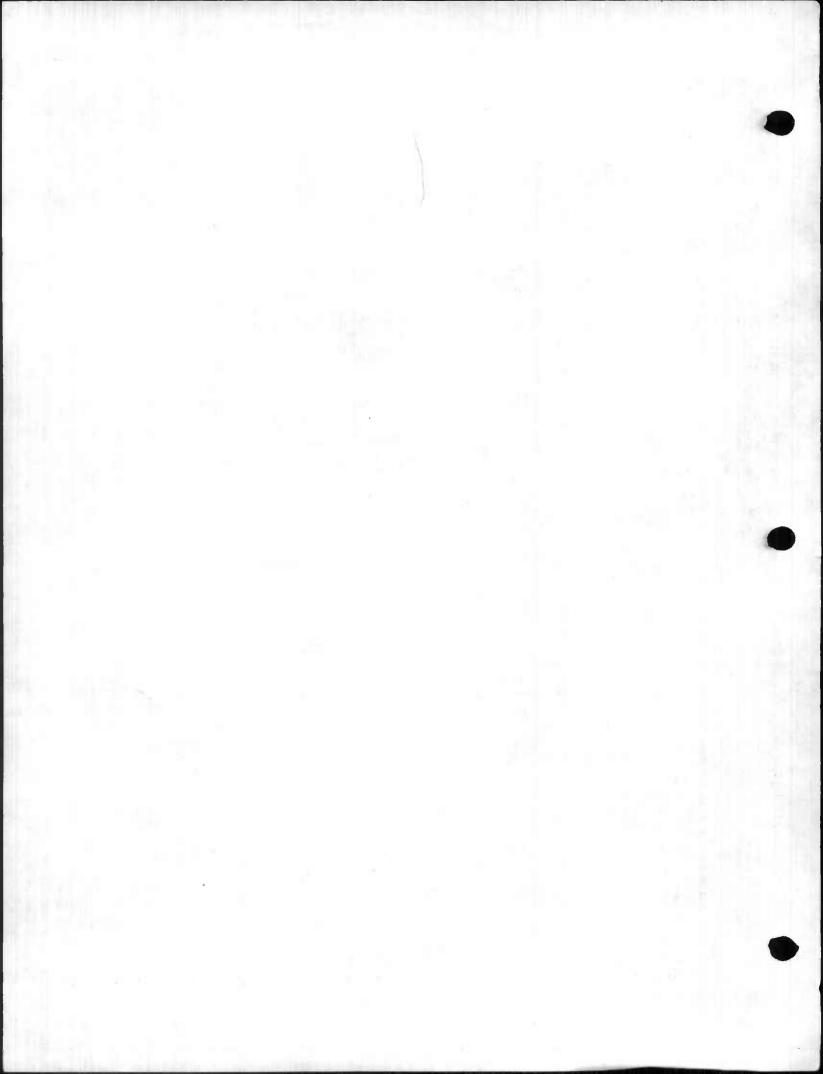
State of Maryland / Department of Health and Mental Hygiene Q

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	Physician /Medical		. Albi				2. Data of Dea Month MAY	Day	Year 999	3. Time of Death 7:01P.M.	
	Examiner	4a Facility Name (If not institution, git JOHNS HOPKINS HOS				4b. City, Town, or L BALTIMOR			y of Death		
	Funeral Director	5. Social Security Number 6. 8		ge (In yrs. last birthda) 73 Yrs.	/ If Under 1 Year Months Days	r If Under 24 Hrs.	8. Date of Birth (Month, Day June 8,	Year)	9. Birthp	place (Stata or Foreigntry) ryland	
	fand M	Usual Rasidance of Decedent  10a. State 10b. County		10c. City, Town or I	ocation				1	10d. Inside City Limits	
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	with the Ma s or 2ta-f. be notified	10e. Street and Number			10f. Zip Code		1	10g. Citizen of			
	her death related siner must Funeral	1637 Lochwood F	12. Was Decedant	Evar in U,S. 13	. Was Decedent of	21218 Hispanic Origin? (Sp ban, Mexican, Puarto	pecify Yes or No-	Unite 14. Rad	ce - Americ	can Indian,	
21215-0020	est, o	1 X Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces' 1 [X] Yas 2 [ If Yes, Give Yaar or Datas:	No	If Yes, specify Cult  1 ☐ Yes 2 🛱 No		o Rican, afc.)	Specify Specify	ick, White, by:	onc. White	
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212	ed within 72 ho typiene. Nor then "neturn if, the Medical.] Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	oad Inspe			Bal	timor	re City	
Pu	that Hyd other event,		17. Father's Name (First, Middle, Last)			18. Mother's Nam		Maiden Suman			
Maryland	d Men d Men marks marks	Louis Albi  19a. Informant's Name/Retationship	Type Print)	10h Mai	ting Address (Steed	Concett		Saia	Ctata Tir	o Codo)	
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timore,	Pages ment of ant: If it ury or o	1 Burial 2 Cremation 3 4 Donation 5 Other (Special	(y)	Parkwoo	d Cemeter		5/28/99	Balti	more.	Maryland	
Balt	Departit Departit Import any in	21. Signature of Funeral Service-Lice	Michael I		22. Nama and Addr LEONARD	J. RUCK,	INC.		arfor	d Road	
	Physician /Medical Examiner	23a. Part1. Enter the disaase, or com shock, or heart failure. List only transport to the control of the control transport to the control of	plications that cause one cause on each t	Due to (or as a conse	dequence d():	-	or respiratory are		1 1 1 1	Approximata interval Between Onset and Death	
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	at the death cert d by the attending etached for use a	Part II. Other significant conditions of	ontributing to death b	out not resulting in the	underlying cause o	iven in Part I.	23b. Did to	obacco ues ca	entributs t	o the cause of death	
s, P.0	requires that the death cer seen signed by the attendin hould be detached for use eted by Physician/W	-47-47-					1 🗆 Y		3 Pro		
Records,	P 2 S P						24a. Was a perfor		av	Vare autopsy findings vailable prior to completion of cause death?	
=	ysiclan: The list certificate he director, page	25. Was case referred to medical					1 ( Y	40 245110	18	Yes 2 No	
<u> </u>	hysician his certifi il director	examiner?	Hospital:	ent 2 X ER/Outpatie	ent 3 DOA Ot	26. Place of Deal			ner (Specil	(v)	
Division of	or Attending P. Iffer death.  Mrector: After ti in by the funera  striffication:		27. Manner of Death    Number of Death   Street end Number or Bural Route Number of Bural Route Number or Bura								
	Hospi 24 hou Funer fely fill	29a. Certifier 1 Certifying Ph (Check only one) 1 Certifying Ph	ysician: To the best niner: On the basis o and manner st	ot my knowledge, dea f examination and/or is ated.	th occurred at the tinvestigation, in my	ime, date and ptace, opinion, death occur	and due to the cred at the time, d	ause(s) and mi	anner as s	tated. o the cause(s)	
	To the within 2 To the comple	29b. Signature and fitle of certifier	ner. A	1.0		.M.E.		MAY 26			
1	XX	30. Name and address of person who	Pesta	ner		n Street,	Baltimo	ore, Mai	rylan	d 21201	
	State	31. Date filed (Month) Dey, Year)	32. Registr	ar's Signature	6	1 .					

DHMH 16 Rsv 6/95

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month **Physician** Armsteac 0030 avid /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) BaHimore, 1111

"Inder 24 Hrs. 8. Dela of Birth (Month, Day, 22) Examiner 9. Birthplaca (Stata or Foreign Maryland Baltimore niversity 5. Social Security Number 225-20-44b 7. Age (In yrs. last birthday)
72
Yrs. If Under 1 Yeer **Funeral** 1 M 2□ F Months Days Director Usual Rasidance of Dacedant the Meryland 10a. Slete 10c. City, Town or Location 10b. County 10d. Insida City Limits ma 23a or 28a-f ehov mant be notified at 12 Yes 2 □ No BALTIMORE MD. Director 10f. Zip Coda 10e. Street end Number 10g. Citizan of What Country? 21205 AVE Funeral death 7 is marked other than "natural", or items : treumatic event, the Medical Examiner ma 12. Was Dacedenl Ever in U.S. Was Decedenl of Hispenic Orlgin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. 11. Merital Stetus Armed Forcas?

1 Pres 2 No
If Yas, Giva
Yaar or Datas: Black, Whita, atc. filed within 72 hours efter 1 Navar Marriad 2 Married altimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: SpecitiB/ACK à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamanlary/Secondary (0-12) Collega (1-4or 5+) Hygiene. STAL employee 12 th NIA (TRUCK DRIVE Pages 1 and 2 should be filed vient of Health and Mental Hygient: If item 27 to marked other t 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Be ORA 19a. Informant's Name/Ralationship (Type, Print) RMSRAC 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Ashland of Health a 6ATTO. MO. 21265 2518 AVC MAINE 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) Date 20c. Location - City or Town, State 1 Surial 2 ☐ Cramation 3 ☐ Ramoval from Stata 6 Depertment of Owings GARRISON Forest V.A. Com 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature Funaral Service Licensaa 22. Nama and Addrass of Facility FUNERA HAND 23a. Pant Linter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or rasplratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset end Death **Physician** /Medical Immediata Cause (Final disease or condition resulting in death) **Examiner** Examiner Acidosi. buriel-trans Saquantially list conditions, if any, leading to Immadiata causa. Entar Undarlying Causa (Disaase or Injury that initiated events resulting in daath) Last pue Dua to (or as a consequence oi): Records, P.O. Box 68760, requires that the death certificate be Physician/Medical the Dua to (or as a consequance of): USB BS ed by the e Part II. Other algnificant conditions contributing to death but not resulting in the undarlying causa givan in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No signed by þ 90 24b. Were autopsy lindings evailable prior to completion of cause of deeth? director, page 2 should Completed 24a. Was an autopsy After this certificate has been To the Hospital or Attending Physician: The law within 24 hours efter death.

To the Funeral Director: After this certificate hes t 2 19 No 1 Yes 2 No 1 TYAS Division of Vital Be 25. Was casa rafarred to medical 26. Placa of Death (Chack only ona) Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 2 1 Yes 2 No 1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar ol Death 28c. Injury at Work? Certification: 28b. Time of 28d. Dascribe how injury occurred 5 Pending invastigation 1 B Natural 2 Accident 3 Suicida 6 Could not be datarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, larm, streat, factory, office building, atc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. 29a. Cartifian Medical

29c. Licansa number

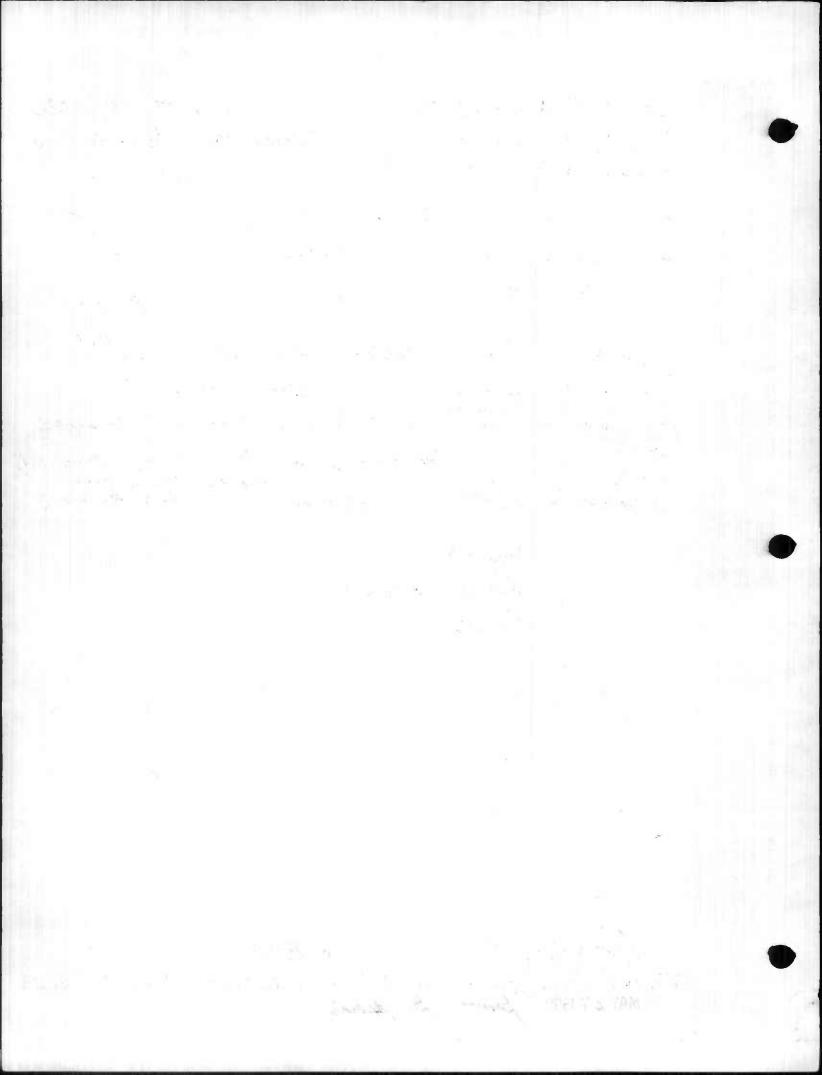
2. Ragistrar's Signature

of Causa of daath (Itam 23a) (Type, Print)
of Maryland 22 South Greene Street Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and fitterof certifier

30. Nama and



WRC 99-2951-011 Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. UNK. 99-109 State of Maryland / Department of Health and Mental Hygiene TROY DEVRON BURRELL Certificate of Death 1. Decedent'a Name (First, Middle, Lest) 2. Date of Death 3. Time of Death Month **Physician** BURRELL IROY 21, 1999 MAY 10 :25 AM 4a Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner RT.578 AND DOVER BRIDGE RD. PRESTON Birthplece (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 01-25-71 5. Sociel Security Number 7. Age (In yrs. last birthday) Sex 1 ☑ M 2 ☐ F **Funeral** Days Hours Months 85-78-7348 Yrs 28 MD Director Usual Residence of Decedent 10a. Stete 10d. Inside City Limits 10b. County 10c. City, Town or Location BALTIMORE 1 Yes 2 No NIA MD 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? à b 238 109 DOLPHIN USA 21217 STREET Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece · American Indian, Black, Whita, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status hours after 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 3□ Merried 15 altimore, Maryland 21215-0020 1 Yes 2 No Specify: BLACK Specify: p 3 ☐ Widowed 4 ☑ Divorced Year or Dates: Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) DELIVERY DELIVERY URIVER II TH GRADE 17. Father's Name (First, Middle, Last) 18-Mother's Neme (First, Middle, Meiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental BURRELL NOEMAN MATRICIA 2 WILLIAMS 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) . Department of Health, Important: If Item 27 is any injury or other tra 109 DOLPHIN PATRICIA MOTHER BALTO MO 20b. Pleca of Disposition (Neme of /cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from Stete 4 □ Donetion 5 □ Other (Specify) MEMORIAL ARK 6.26.99 KANDAUSTOWN, 21. Signeture of Funeral Service Licensee 22. Name end Address of Facility VAUGHN C. GREENE FUNERAL SERVICE BALTO MO. 21229 5151 BAUTO. NATE PIKE, 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or hear failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Final diseese or condition resulting in deeth) Examiner Due to (or as a o Examiner Sequentially list conditiona, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of) that the death certificate be execu 68760 Physician/Medical Due to (or es a consequence of): Box ( signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? P.O. 1 Yes 2 No 3 Probably 4 Unknown Records. by The law requires 24e. Wes en autopsy performed? 24b. Were eutopsy tindings available prior to Completed completion of cause of death? page 2 1 X Yes 2 □ No 1 Yes 2 No certificate Vital Physician: director 25. Wes case reterred to medical 8 26. Place of Deeth (Check only one) AT Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Certification: To 1XXYes 2□ No 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA of this SCENE funeral 28a. Dete of Injury (Month, Days) ear 28c. Injury at 27. Menner of Death 28b. Time of 28d. Describe how injury occurred After Truc Division or Attending 5 Pending investigation Injury 281. Location (Singlet and Number City or Town State) Driver 1 Neture mest 21/99 Yes 2 □ No death. 0455 2 Accident after death 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 - Homicide eston 4 24 hours a Hospital 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated Medical tely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and plece, and due to the ceuse(s) and menner steted. within 2 the th 29d. Date signed (Month, Day, Year) 29b. Signature end Affile of certifier 29c. License number

State Registrar

**DHMH 16 Rev 6/95** 

31. Date tiled (Month, Dey, 1999

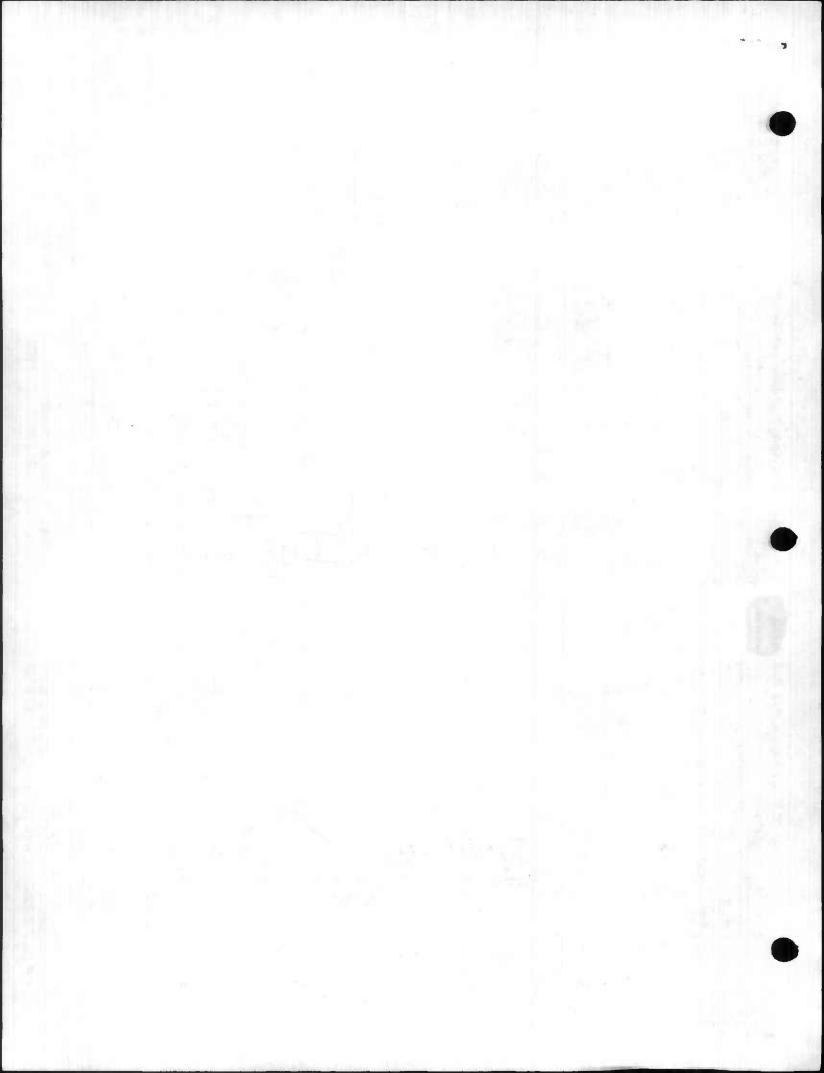
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tane 111 Penn Street, Baltimore, Maryland 21201 32. Registrer's Signeture

ss of person who completed cause of deeth (Item 23a) (Type, Print)

O.C.M.E.

MAY 22, 1999



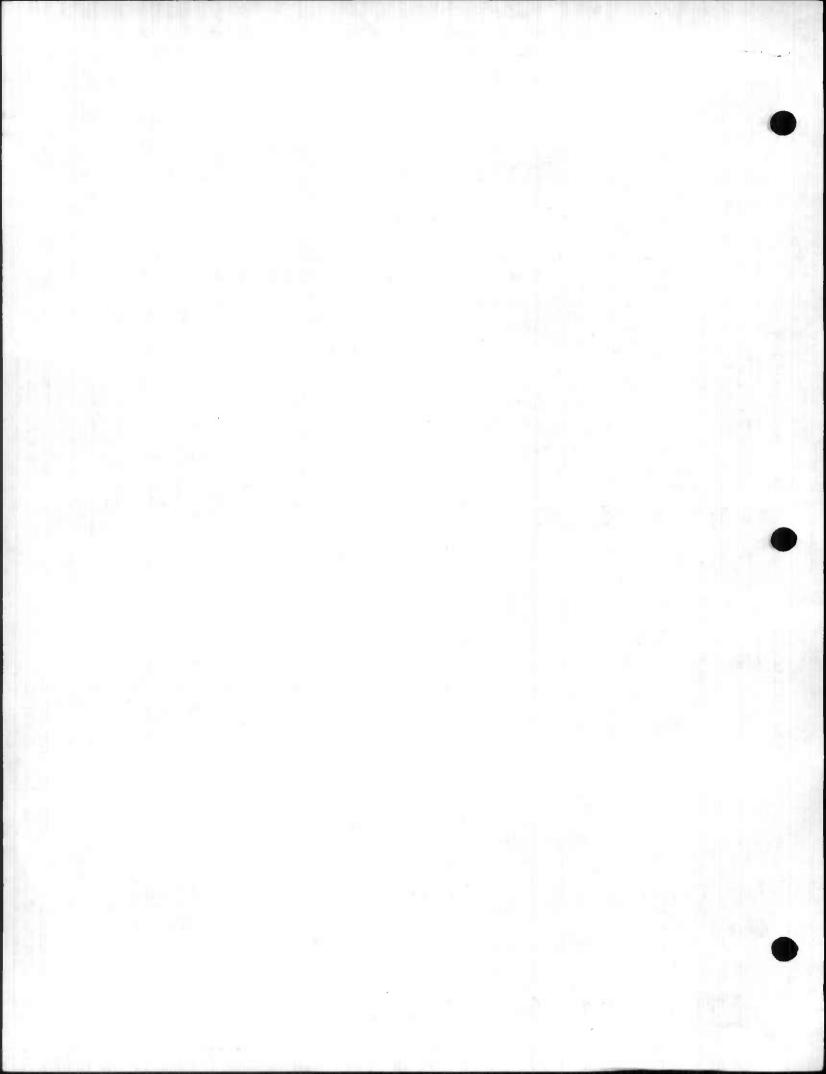
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State of Maryland / Department of Health and Mental Hygiene Q

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DEBO	RAH BLU	JNT				Ce	rtificat	te of	Death			Rec	J. No.			
1		1. Decedent's Nama (First, Min	idia, Last)								2. Date	of Death			3. Tima of	f Death
	Physician	ULUMN DI	UNT								Month MAY	)	Dey 19, 19	Year 999	4:40F	M
81	/Medical	An English Name (Mant Institu		reet end nur	nber)				4b. City, To			Death	4c. County		1.101	/
	Examiner	7141 BEXHILL			,				WOODL	AWN.			BALT			
—		5. Social Security Number	6. Sex		7. Age (In vrs	. last birthday	If Under	r 1 Year			8. Date of	of Birth				or Foreign
	Funeral Director	218-98-7914 Usual Residence of Decedent		M 202 F	35	Yrs.	Months	Deys	Hours	Min.	8. Date of (Month)		(ear)	Cou	place (State of	or r orongr
Pue	ž	10a. Stete 10b. Cour	ity		10c. C	ity, Town or Le	ocation							1.	10d. Inside C	ity Limits
VIZI 5-0020 within 72 hours after death with the Maryland	al", or hams 23a or 28a-f above Examiner must be notified at by Funeral Director	MD	NA			LTIMOR									1 🗹 Yes	2 □ No
=	or 2	10e. Street and Number		0			10f. Zip	Code	0			100	g. Citizen of	What Cou	ntry?	
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9	r heme 23.	11. Marital Stetus	12	2. Wes Dece	dent Evar in I	U,S. 13.	Wes Dece	dent of	Hispanic One can, Mexican	gin? (Spe	ecify Yes o	r No-		ce - Americk, Whita,	can Indian,	
d within 72 hours after	natural, or h	3 ☐ Widowed 4 ☐ Divord	arried	1 ☐ Yes If Yes, Giv Yaer or Da	2⊠No e		1□ Yes	/				,	Specif		ACK.	
2 2	yglene. Ner than "natura ft, the Medical Completed	15. Deced	ent's Educa	ation		16a. Dece	dent's Usu	el Occu	pation			16	5b. Kind of B	usiness/In	dustry	
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4	ortant: ortant: Injury B	4 Donetion 5 Other			AR	BUTUS 1		ETE			29 19	19 K	SALTO.	mo		
Dallinore,	Department of Health important: If Nem 27 any Injury or other to once.	21. Signeture of Funerel Servi	Licensee	- 1	1				ass of Facilit		= =	INITE	201 4	SEP.		
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	Medical	Immediate Cause (Finel			Shal	zun	11/2	0	2.	I	-000			1		
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9	physician and s the burial-transit edical Examir															
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death certificate be executed	d by the attend etached for use Physician/															
) §	ed by the detached	Part II. Other significant cond	tions contri	ibuting to de	ath but not re	sulting in the u	inderlying o	ause g	iven in Pert I.		23b.	Dld tob	acco use co	ontribute t	to the cause	of death
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he law requires the	page 2 should Completed										24a.	Was en	eutopsy ed?	24b. W	ere autopsy vailable prior	findings to
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Ibendi death	the cat	2 Accident Inve	stigetion		-19-99		#M		Yes 2				shot			
or Attending		4 Homicide dete	mined	28e. Plece of Injury - At home, tarm, etreet, tectory, office building, etc. (Specify)				1	28t. Location (Street and Number or Rural Route Number, City or Town, State) 7,41 Bex hill Rook				Road			
3	2 0						no	me			Round	alls,	town,	Kd		
- Hospital	To the Funeral Directory Completely filled in b	29e. Certifier 1 Certification Check only 2 XMedication one)	ring Physic al Examine	cian: To the er: On the ba and mann	sis of examin	owledge, deet etion end/or in	h occurred vestigation	at the t	ime, dete en opinion, dee	d place, o	end due to ed et the t	the cau ime, dat	se(s) and m e end plece,	enner as s end due t	stated. to the ceuse(	5)
To the	Me din	29b. Signeture and title of certi	lier	10011			29	c. Licen	se number			290	d. Data signe	ed (Month.	Dey, Year)	
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				TONGS !	₩.				. I. Li.			1.15	20,			
		30. Neme end address of person	n who com	pleted cause	ot death (Ite	m 23a) (Type,										
		Dennis J. C	hufe	MD			111	Pen	n Stre	et,	Balt	imor	re, Ma	rylan	d 2120	)1
	State	31. Date filed (Month, Day, Yell MAY 2, 7, 1999)	(r)	32. Re	gistrer's Sig	ature										
	Registrar	MAT 2 7 1999	1	- Jan	10	. 100	als									

**DHMH 16 Rev 6/95** 



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year **Physician** ANNA BELLE BOLTON MAY 25 1999 7:35 AM /Medical 4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1422 PATAPSCO STREET BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) West Virginia 8. Date of Birth (Month, Day, Yea **Funeral** Days Months Hours 1 M 2 KF 84 216-36-9035 Yrs. Director Jan.31 1915 Usual Residence of Decedent the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Nem 27 is marked other than "natural", or Nems 23s or 28s-f show other traumatic event, the Medical Exercises must be notified at Director Md. n/a Baltimore 1 Yes 2 No 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21230 USA 1422 Patapsco Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Rece · American Indian, Black, White, etc. filed within 72 hours efter 1 Never Merried 2 Married 1 Yes 2 No 00 1 ☐ Yes 2 ☐ No Specify: aitimore, Maryland 21215-0020 Specity: à white 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within 7. Department of Heelth and Menial Hyglene. Important: if item 27 is marked other than "na eny injury or other traumatic event, the Media once. Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Store Operator Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) B Phoebe Eye 2 Blaine Day 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1422 Patapsco Street, Baltimore, Md. 21230 <u>Juanita Crispens (Daughter)</u> 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removel from State 5/28/99 Pendleton, W. Va. Cedar Hill Cemetery 4 ☐ Donation /5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 130 E. Fort Ave. Baltimore, Md. 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on such line. Approximata Interval Between Onset and Death **Physician** Immediete Cause (Final disease or condition resulting in death) /Medical puovasa Weels Examiner ASCO requires that the death certificate be executed buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last P Due to (or as a consequence of): Records, P.O. Box 68760. attending physicien for use as the burie Physician/Medical Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Diseure ģ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy peed completion of cause of death? The lew 1 Yes 2 No 1□ Yes 2 No this certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, i Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Medical Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO 1317 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

**DHMH 16 Rev 6/95** 

State Registrar Herman

32. Registra e Signature

2337 N. Rolling Rd.

Trans of the second of the second

99-3004-021

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

**EDWARD** 

State of Maryland / Department of Health and Mental Hygiene \( \)

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Yes 2 No

DI	Saup
	Physician
	/Medical
	Examiner

DICTION

ITEM#23a & 27 PER MEO G772 6-4-99 J.A. 1. Decedent's Name (First, Middle, Last) Edward Louis Bishop

Certificate of Death

2. Date of Death

Month

MAY

3. Time of Death 1999 12:15P.M. 24,

4a Facility Name (If not institution, give street end number) FREDERICK MEMORIAL HOSPITAL 4b. City, Town, or Location of Death

FREDERICK

4c. County of Deeth

FREDERICK

10g. Citizen of What Country?

**Funeral** Director

"natural", or items 23s or 28s-f show adical Examiner must be notified at

Director

Funeral

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Completed

Be

0

Examiner

Physician/Medical

by

Completed

Be

edical Certification: To

with the Maryland

death

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if them 27 la marked other than "natural", or item page.

Baltimore, Maryland 21215-0020

Usual Residence of Decedent 10b. County WV

If Under 1 Yeer | If Under 24 Hrs. 7. Age (In yrs. last birthday) Days Months Hours

10f. Zip Code

26808

8. Dete of Birth (Month, Dey, Year) Mar 16 1936 Birthplace (State or Foreign Country)
 NY

132-28-0790

Hampshire

10c. City, Town or Location High View

10d. Inside City Limits

USA

10e. Street and Number

Route 1, Box 405

12. Was Decedent Ever in U.S. Armed Forces?

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

14. Race - American Indian Bleck, White, etc. Specify: White

11 Marital Status

1 Never Married 2 Merried 3 Widowed 4 Divorced

1 Yes 2 No 1969
If Yes, Give
Year or Dates:

1 Yes 2 No Specify:

16b. Kind of Business/Industry

15. Decedent's Education (Specify only highest grede completed) Elementary/Secondery (0-12)

College (1-4or 5+) +8

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) pastor

christian church

17. Father's Neme (First, Middle, Last) George Bishop (30 HHO.

19a. informant's Neme/Relationship (Type, Print) Phyllis Bishop (spouse)

Martha Grey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Route 1, Box 405, High View, WV 26808

18. Mother's Name (First, Middle, Maiden Surneme)

20b. Place of Disposition (Neme of ometery, cremetory or other plece)
OMPS Cremation Serv.

Date 20c. Location - City or Town, State 5-31-99 Winchester, Va.

20e. Method of Disposition

1 ☐ Buriel 2X Cremation 3X Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify)

22. Name and Address of Facility Haight Funeral Home & Chapel

21. Signature of Funerel Service Licensee erwers Haraht

P.O. Box 195 Sykesville, Md 21784 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart feilura. List only one cause on each line.

**Physician** /Medical Examiner

burial-transit

attending physician for use as the buna

been signed by the should be detach

paga 2 certificate

director.

this

After

death.

within 24 hours after deat To the Funeral Director: filled in by the

Hospital or

To the

The law requires that the death certificate be asscuted

68760.

Box

P.O. |

Records.

Division of Vital Attending Physician: Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last

Immediate Cause (Final disease or condition resulting in death)

ATHEROSCLEROTIC	CARDIOVASCULAR	DISEAS
Due to for se a consequence	W).	

Due to (or es a consequence of):

Due to (or es a consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Junknown

24a. Was en autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

Approximate Interval Between Onset and Death

1/9 Yes 2 No

25. Was case referred to medical No Yes 2□ No

28e. Dete of Injury (Month, Day Year) 5 Pending investigation

1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 28b. Time of 28c. injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

26. Place of Deeth (Check only one)

1 ☐ Yes 2 ☐ No

29e. Certifier

27. Menner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier

29c. License number O.C.M.E.

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

MAY 25, 1999

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

30. Name and address of person was completed cause of deeth (Item 23a) (Type, Print)

Dennis

6 Could not be determined

111 Penn Street, Baltimore, Maryland 21201

State Registrar 1999 Registrar's Signature

## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State o

of Maryland / Department of Health and M	Mental Hygiene 99	17008
Certificate of Death	Reg. No.	

3. Time of Death 6:30 A.M

1 ☐ Yas 2 No

**Funeral** 

Director

the Marylenc

OSEP

BURTON

10a State

Directo 7 is marked other than "natural", or items 23s or traumstic event, the Medical Examiner must be Funerai by Completed Be

72 hours after deeth with filed within 7 Hygiene. Pages 1 and 2 should be fleen of Health end Mentel of Health Department of Important: If It eny Injury or o

**Physician** /Medical **Examiner** 

Examiner physician and s the burial-transit Physician/Medicai 65 USB signed by the a d be datached for þ Completed page 2 has certificata 9 Certification:

requires that the death certificate be axecuted P.O. Box 68760 Division of Vital Records, Hospital or Attending Physician: funeral director After this efter deeth. 24 hours e To the Hosp within 24 hor To the Fune completely fi 1. Decedent's Nema (First, Middle, Last) 2. Data of Death Month MAY ALLEN BURTON 26 1999 4b. City, Town, or Location of Death 4a Facility Nema (If not institution, giva street and number) 4c. County of Death GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE 7. Aga (In yrs. last birthday) If Undar 1 Yaar If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Sex 1 M 2 F Birthplaca (Stata or Foreign Country) Months Days Hours Min Yrs. 218-12-9754 74 JULY 3, 1924 MARYLAND Usuel Rasidence of Dacedent 10b. Counts 10c. City, Town or Location 10d. Insida City Limits MARYLAND ANNE ARUNDEL LINTHICUM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6585 ENGLEWOOD ROAD 21090 U.S.A. 12. Was Decedent Evar in U,S. Armed Forcas? 1 ⊠ Yas 2 □ No If Yes, Giva Yaar or Datas: 1943-46 14. Race - American Indian. Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxicen, Puerto Rican, etc.) Bleck, White, atc. 1 Navar Married 2 N Married 1 ☐ Yas 2 X No Specify: WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working iifa. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Elemantary/Secondary (0-12) College (1-4or 5+) TRUCKING & CONTRACTING CHIEF EXECUTIVE OFFICER 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Sumama) LEONARD BURTON MYRTLE SHEELER 19a. Informent's Neme/Raletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 6585 ENGLEWOOD ROAD, LINTHICUM, MARYLAND 21090 HELEN R. BURTON (WIFE) 20b. Plece of Disposition (Name of cemetary, cramatory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ♥ Burial 2 □ Cramation 3 □ Ramoval from Stata 4 ☐ Donetion 5 ☐ Other (Specify) WOODLAWN CEMETERY 5/29/99 BALTIMORE, MARYLAND 21. Signatura A 22. Nama and Addrass of Facility SINGLETON FUNERAL HOME, P.A. 1 SECOND AVE. S.W., GLEN BURNIE, MD 21061
s. of complications that coused the death. Do not antar the mode of dying, such as cerdiac or respiratory arrest,
List only one couse on each line. Approximata Intervel Between Onsat and Death Immediata Causa (Final disaasa or condition rasulting in daath) consaquance of): Sequentially list conditions, if any, laading to immadiate ceusa. Enter Undarlying Ceusa (Disease or Injury that initieted events resulting in death) Last (or as e consequence of Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24a. Was an autopsy

23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

2 . No 1 🗆 Yas

24b. Wara autopsy findings evailable prior to completion of ceuse of death? 1 Yas 2 No

25. Was cesa rafarrage to medicel axeminar? 1 Yes 2 No 27. Menner of Death

2 Accident

3 Sulcida

29a. Certifier

edical

4 Homicida

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Invastigation 6 Could not be

1 Inpatient 28a. Deta of Injury (Month, Day Year)

Hospital:

30. Nama and addrass of person who complated ceusa of daath (Itam 23a) (Type, Print)

2 ER/Outpatient 3 DOA 28b. Time of

28e. Plece of injury - At homa, farm, streat, factory, office building, etc. (Specify)

Othar: 4 ☐ Nursing Home 5 ☐ Rasidance 6 ☐ Other (Specify) 28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28d. Describe how injury occurred

26. Placa of Death (Check only ona)

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature title of certified

29c. Licansa number

29d. Data signed (Month, Dav. Year)

Location (Street and Number or Rural Routa Number, City or Town, Stata)

State Registrar 31. Date filed (Month, Pay, Year) 1999

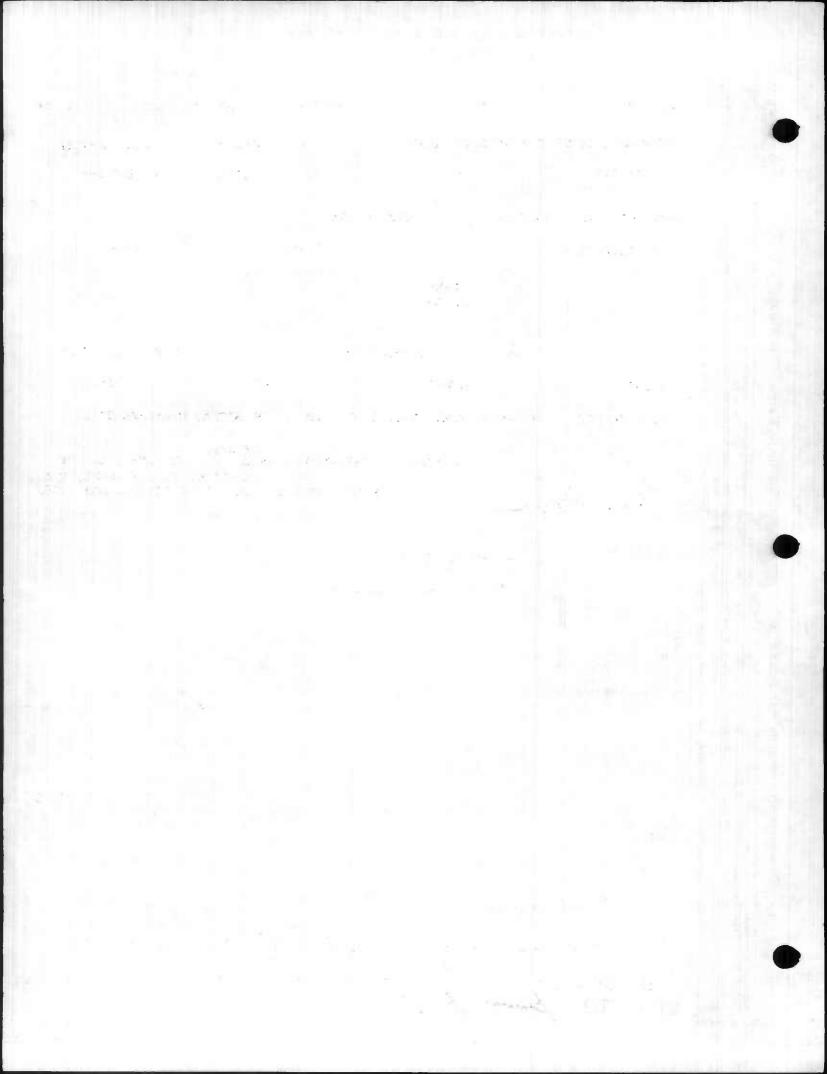
32. Registrar's Signatura

Sall Sall Land. Control Contro Plant Promo Promo Plant SOR - Care

# Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** WILLIAM N. BIESEL 24, MAY 1999 8:48 AM /Medicai 4a Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CRANBERRY COTTAGE ASSISTANT LIVING GLEN BURNIE

If Under 24 Hrs. 8. Data of Birth
Hours | Min. (Month, Day, Year) ANNE ARUNDEL If Undar 1 Yaar 5. Social Security Number 6. Sex 1□ M 2□ F 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Months Days Yrs. 317-14-0712 Director 75 FEB. 7, 1924 INDIANA Usual Residence of Decedent the Maryland r 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits GLEN BURNIE 1 Yes No ANNE ARUNDEL MARYLAND Directo 10e Street and Number 10f Zin Code 10g. Citizen of What Country? permit. Pagas 1 and 2 should be filed within 72 hours aftar death with t Departmant of Haatth and Mental Hygiana. I be professer if flem 27 is merked other than "naturel", or flems 23a or 2 any injury or other traumatic event. h and Mental Hygiena. 7 is marked other than "naturel", or itema 23a or traumatic event, the Medical Examiner must be r 21060 U.S.A. 1709 KIMBER ROAD Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1. 18 Yas 2 □ No DATES Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 If Yes, Give Year or Datas: UNKNOWN 1 ☐ Yas 2 ☑ No Spacity: WHITE þ 3 Widowed 4 □ Divorcad Completed 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) +5 ACCOUNTANT U.S. GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Surname) Be BIESEL BIESEL GOLDIE MATHIAS 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2302 230TH STREET, PASADENA, MARYLAND 21122 (STEP-DAUGHTER) RHONDA ORANGE 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 5/26/99 1 ☐ Burial XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CENTER, LLC. STEVENSVILLE, MD. 21. Signature of Robinal Selvice Licensee 22. Nama and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner sician and burial-transit a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury that in it leads are only in the conditions of t Due to (or as a consequence of) physician the burial Box 68760. the death cartificate be Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) 88 USB Po ed by tha a Part II. Other stanificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco uss contribute to the cause of death? o 1 Yss 2 No 3 Probably 4 Unknown signed b Records, à 24b. Were eutopsy tindings available prior to 24e. Wes en autopsy Completed completion of cause of death? paga 2 1 Yes 2 No 1 ☐ Yas 2 ☐ No cartificata Division of Vital or Attending Physician: assisted living director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 0 1 Inpatient 2 ER/Outpatient 3 DOA this funaral 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? Aftar 1 Ratural 5 Pending aftar daath. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide • Funeral [ Hospital 29a. Certifier Decrifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the ceuse(s) end menner as steted. Medical complataly (Check only one) 2 Msdicat Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. within 2 4 29b. Signature and title of cartifier 29c. Licensa number 29d. Date signed (Month, Day, Year) 0 usna MI) 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 4660 WICKENS AVE \$ 100 BUCRSMA BALT MD 21229 NAY 2 7 1999 32. Registrer's Soneture State Registrar



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2 Date of Death Month AM Elizabeth B. Bailey on of Deeth 4b. City, Town, or Location 4a Fecility Name (If not institution, giva street and number) Bel Air Il Under 24 Hrs. Min. 8. Data of Birth (Month, Day, Year) Mariner Health of Belair If Under 1 Year Birthplaca (Stata or Foreign Country) 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) 1 □ M 2 🖾 F Months Days 90Yrs. 221-01-2119 Sept. 11, 1908 Ohio Usuel Rasidance of Decedant 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas a☐ No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 410 E. MacPhail Road 21014 U.S.A. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indien, Black, Whita, atc. 1 □ Yes 2 ☑ No If Yas, Give Yaar or Datas: 1₺ Navar Marriad 2 Married 1 ☐ Yas 2 ☑ No Specify: white Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedant's Education (Specify only highast grada complated) 16a. Dacadant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) 12 4 teacher music 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) William T. Bailey Maude Minnie McGara 19a. Informant's Name/Raletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) George S. Hanna/nephew 1 E. Mac Phail Road, Bel Air, MD 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burlel 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 X Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Sarvice Licensee 22. Name end Addrass of Fecility Ronald S State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201 23a. Partl/ Enter the disease, or demplications the caused the death. Do not anter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. META STATIC AD SU OCATELLEA Onsat and Death Immediete Causa (Finel diseasa or condition rasulting In deeth) week Penney UNKNOWN Dua to (or as a consequence of): Sequentially list conditions, if any, laading to immediata cause. Entar Undarfying Cause (Disaasa or Injury that initiated avants resulting in daath) Last Dua to (or as a consequence of) Dua to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Was en eutopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 26. Plece of Deeth (Check only one) Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Mennes of Death 28b. Tima of 28d. Describe how injury occurred 28e. Data of Injury (Month, Day Year) 28c. Injury et Work? 1 Natural 5 Panding 1 Yas 2 No investigation 2 Accidant 6 Could not be datarminad 3 Suicida 28a. Placa of injury - At homa, farm, straat, factory, office building, atc. (Spacify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicida

2 eigned by li zabeth has page 2 certificate 装

Athar

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show

7 is marked other than "natural", or items 23s or traumstic event, the Medical Examiner must be a

permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: if them 27 la merked other than "natural", or items 23s any injury or other traumatic event, the Men

**Physician** 

/Medical

Examiner

Examiner

Physician/Medical

by

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Be

Certification: To

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by

Completed

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> 25. Was casa raferred to medical axaminar? 1 Yas 2 No

29a. Cartifiar (Check only one)

t 🗹 Cartifying Phyelcian: To tha bast of my knowladge, death occurred at tha time, data end placa, and dua to the ceuse(s) end mannar as stated. 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner steted.

29b. Signature and titla of cartifier

27

29c. Licansa number

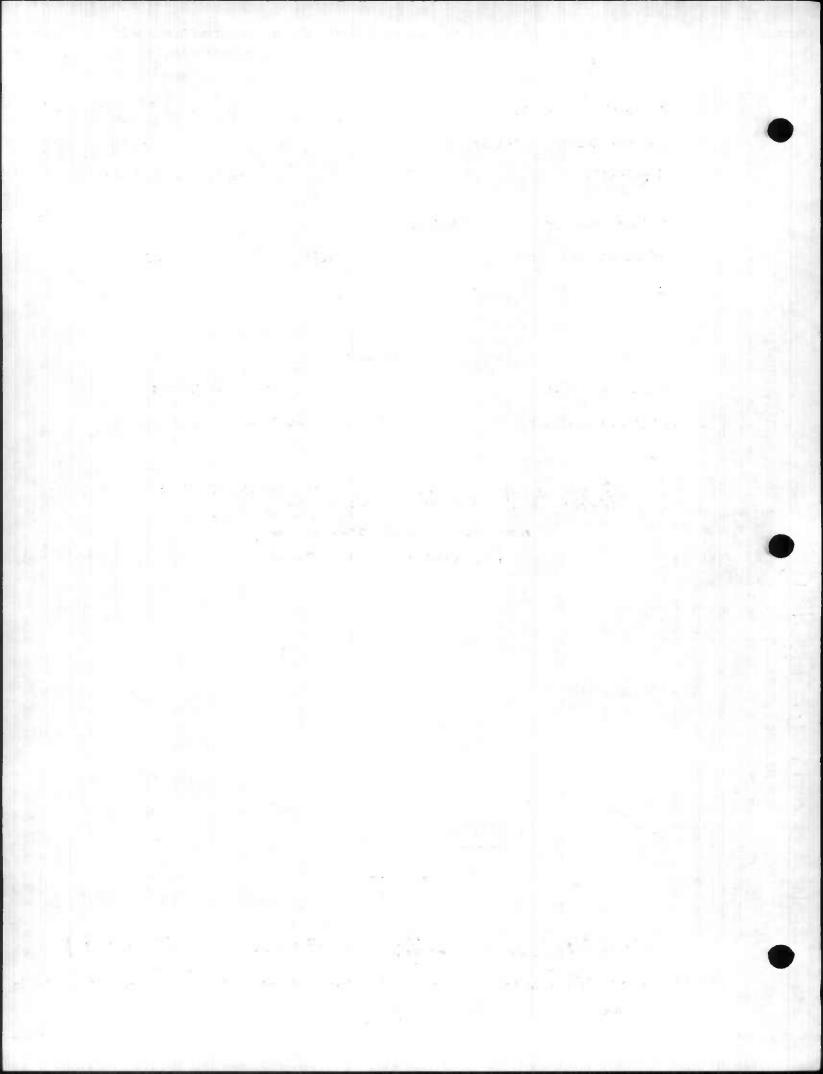
29d. Data signed (Month, Day, Year)

30. Neme end addrass of person who completed causa of death (Itam 23a) (Type, Print)

Red Bel Aremozioi4 W. MAC 61

State Registrar 32. Ragistrar's Signatura

To the Hor within 24 h To the Fur



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 7

	1. Decedent's Name (First, Middle, Last)		Cerui	icate of	Dealli	2. Date of De	Reg. No.		3. Time of Death
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Medical	4a Facility Name (If not institution, give stree	LSSell C	-reigni	100	4b. City, Town, or L			/999	0540
Examiner	STAGNES HEALTI				BALTIM	_	. 40. County	OI DOOLL	
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs.		Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da	th	9. Birthpi	lace (State or Foreign
Director	2-16-09-5*789 12 M Usual Residence of Decedent	2□F 8	5 Yrs. M	onths Days	Hours Min.	Month, Da	y, Year) 0-1913	Coun	Va Va
No.	10s. State 10b. County	10c. Ci	ity, Town or Location	on				10	0d. Inside City Limits
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tor 28a-f a be notified Director	10e. Street and Number		1	01. Zip Code			10g. Citizen of \	What Coun	itry?
	2001 Bryant	Avenue		211				S.A	
st, or items 25 Examiner must by Funeral	1 Never Married 2 Married	Was Decedent Ever in U Armed Forces? I ☐ Yes 2 M Ño If Yes, Giva Yaer or Detes:		Decedent of I s, specify Cub Yes 2 (No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Blee	e - America ck, White, o y: B/c	etc.
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0 24	54 grade	NA	noul	over					
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e do	20a. Method of Disposition	20b.	Place of Dispositio	n (Name of	1	Date	20c. Location		wn, State
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Depar impor any in	21. Signature of Funeral Service Licenses	buch	_ La	me and Addre	oss of Facility  What  Waba	ish An	enne	Bal	4s, red
hysician	23a Part Enter the disease, or complication to the complex com	on thet caused the dea ouse on each line.	th. Do not enter th	e mode of dyi	ng, such as cardiac	or respiratory a	rrest,		Approximate Intervel Between Onsat and Death
/Medical Examiner	Immediate Cause (Finel disease or condition resulting in death)	CEREBI	RAL VASC	ULAR	ACCIDE.	NT		i	DAYS
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sicien end buriel-transk bai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury		or as a consequent					1	YEARS
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To the American of American Pro- Within 24 hours effect death.  To the Funerel Director: Affect this completely filled in by the funeral  Medical Certification: 7	29a. Certifier (Check only one) 1 Certifying Physician 2 Medical Examiner:	n: To the best of my kno On the basis of examina and manner stated.	owledge, death occ ation and/or investi	urred at the tigation, in my o	me, date and place, opinion, death occur	and due to the red at the time,	cause(s) and made and place,	anner as st and due to	tated. the cause(s)
Withit To the	29b. Signature and title of certifier.	1 7		29c. Licens	se number		29d. Date signe	d (Month, I	Day, Year)
	Janus alge	MD		PI	2594		MAY	25,	1999
	30. Name and address of person who comple				_			, 7. 40	of mo
	JAMES LACEY, NO	ST. AGNO		H CAR	E 900 C	ATON A	VG, BA	61117	ORE, MD
State	31. Date filed (Month, Day, Year) MAY 2.7 1999	32. Registrar's Signa		/					

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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May 20. Joseph Victor Corbi 5:45 PM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 16457 Old Frederick Road Woodbine Carroll If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth Month, Day, Year) DEC. 10, 1944 9. Birthplace (State or Foreign Days 1 M 2 F Hours Maryland 216-44-2071 54 Usual Residence of Decedent 10b County 10c City Town or Location 10d. Inside City Limits Woodbine Carroll 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16457 Old Frederick Road 21797 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Detes: 1 Never Married 2 Merried 1 ☐ Yes 2 ☑ No Specify: white 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Food/Joe Corbi Pizza Owner 17. Father's Name (First Middle Last) 18. Mother's Neme (First, Middle, Meiden Sumema)

P. O. Box 124, Lawrence, Pa.

20b. Place of Disposition (Name of cemetery, cremetory or other place)

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line.

Meadowridge Memorial Pk.

Josephine A. Chiofalo

Date

5/24/99

22. Name and Address of Facility
Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc.

15055

20c. Location - City or Town, State

Onset and Death

Elkridge. Md.

to, 21, 1999

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7250 Washington Blvd., Elkridge, Md.

D20604 Maryland

#450; 10755 Fells Rd, Lutherville, Lol 21093

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a State

Director

Funeral

þ

Completed

Be

Joseph N. Corbi

20a. Method of Disposition

Immediate Cause (Finet disease or condition

19a. Informent's Name/Reletionship (Type, Print)

Rocco Violi - nephew

4 ☐ Donation 5 ☐ Other (Specify)

21. Signalura of Funeral Seryice L

1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State

Kichendo Ben

Richard A. Berg. 40

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

**Funeral** 

Director

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Pages 1 and 2 should be filed within 72 hours after of most of Health and Mental Hyglans.
with If Rem 37 is marked other than "natural", or the ury or other treatmets event, the Medical Examinat

Baltimore, Maryland 21215-0020

with the Maryland

Be Completed by Physician/Medical Examiner 3

or Attanding Physician: The law requires that the desth carlificate be axecuted cartificata this funaral To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After complately filled in by the fun

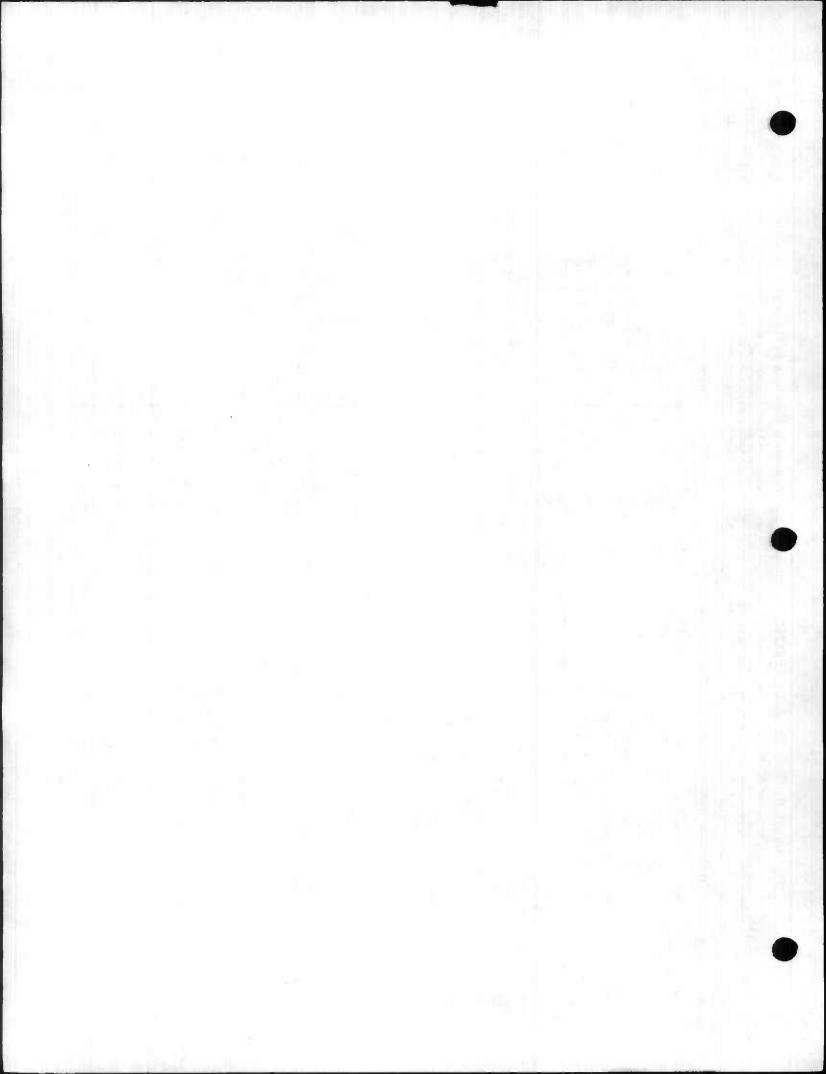
Medical Certification: To

Division of Vital Records, P.O. Box 68760,

Immediate Cause (Finet disease or condition resulting in death)	a preumeni	A			3 deys	
resoning in coatri)	Due to (	or as a consequence of	of):			
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Pert It. Other significant conditions	contributing to death but not re-	sulting in the underlyin	g ceuse given in Pert I.	23b. Did tobacco usa co	ontributa to the cause of death?	
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pemph	gus folicerus			24a. Wes en eutopsy performed?	24b. Were autopsy tindings available prior to completion of causa of deeth?	
neuro	genic bledder on	dunnery tree	d'infection	1 ☐ Yes 2 ☐ No	1 ☐ Yes 22 No	
25. Was case referred to medical examiner?	26. Place of Death (Check only one)					
1 Yes 2 No	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)					
27. Manner of Death  1. ☑ Natural  2 ☐ Accident  2 ☐ Accident		28b. Time of Injury	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occur	rred	
3 Suicide 6 Could not l 4 Homicide determined			ory, office	28f. Location (Street and Number or Rurel Route Number, City or Town, State)		
29a. Certifier 1 Certifying Pi	hysician: To the best of my knominer: On the basis of examinating and manner stated.	owledge, death occurrent ation and/or investigati	ed at the time, date and plac on, in my opinion, deeth occ	ce, end due to the cause(s) and m curred at the time, date and place,	enner as stated. and due to the cause(s)	
29b. Signature and title of certifier			29c. License number	29d. Date signe	29d. Date signed (Month, Dey, Year)	

**DHMH 16 Rev 6/95** 

State Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2 Data of Death 3 Time of Death Month **Physician** DUN HE P. 1 TARIE C /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c County of Deal Examiner 2005. Hammonds Ferry Lynthicum If Under 1 Year | If Under 24 Hrs. 8. Data of Birth Months | Days | Hours | Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1□M 2X F Months Days 90 Director 23, 1908 Maryland 219-03-3312 Nov. Usual Residence of Deceden the Meryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Expressor must be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Linthicum 10e Street and Number 10f. Zip Code 10g. Cifizen of What Country? with 200 S. Hammonds Ferry Road 21090 Funeral U.S.A. death 12. Was Decedant Evar in U.S. Armed Forces? 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, Whita, etc. permit. Pages 1 end 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any Injury or other transment. 1 ☐ Yes 2X No 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 Yes 2♥ No Specify: Specify: white þ 3 Widowed 4 □ Divorced Yaar or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Spacify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown secretary church 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) Be Emil Griffner Minna M. Schmidt 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zio Code) Ada Dornbosh/daughter 872 Main St., Linthicum, MD 21090 20b. Place of Disposition (Name of 20a. Method of Disposition Data 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility Ronald S. Wade, Di rector State Anatomy Board, 655 W. Baltimore Street KEELL Iller Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrast, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final MYNLOCYTIC LRUKENIA . CIMUNIC disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner sician and burial-transit Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 certificeta be Physician/Medical the Dua to (or as a consequence of): 88 use ō ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the causa of death? o signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Wera autopsy findings available prior to 24a. Was an autopsy Completed peed completion of cause of death? 1 Yes 2 No 1 Tyes 2 No certificata Division of Vital Attending Physician: 26. Place of Death (Check only ona) Be 25. Was case referred to madical axaminar? Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funerel 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Dascribe how injury occurred Certification: Affar 1 Naturai 5 Pending invastigation Injury death. 1 Yes 2 No 2 Accident Ne Hospital or Attending 24 hours after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicida Certifying Physician: To the best of my knowladge, daath occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier

State Registrar

JOHN SHAVERS 31. Data filed (Month, Day, Year, MAY 2 7 1999

29b. Signature and title of certifier

CAMPUS MEADE ROAD 32. Registrar's Signature

and manner stated.

30. Name and addrass of person who complated causa of daath (Item 23a) (Type, Print)

bould

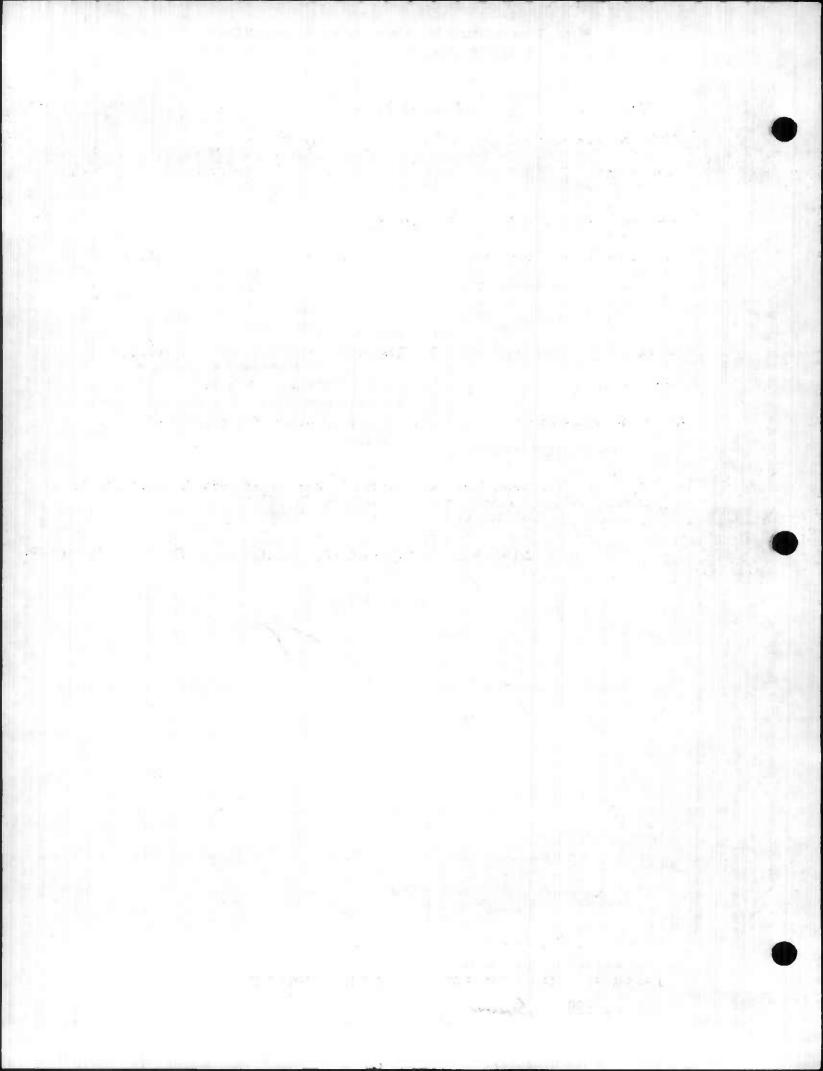
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. Licansa number

LINTHICUM, MARYLAND 21090

29d. Date signed (Month, Day, Year)

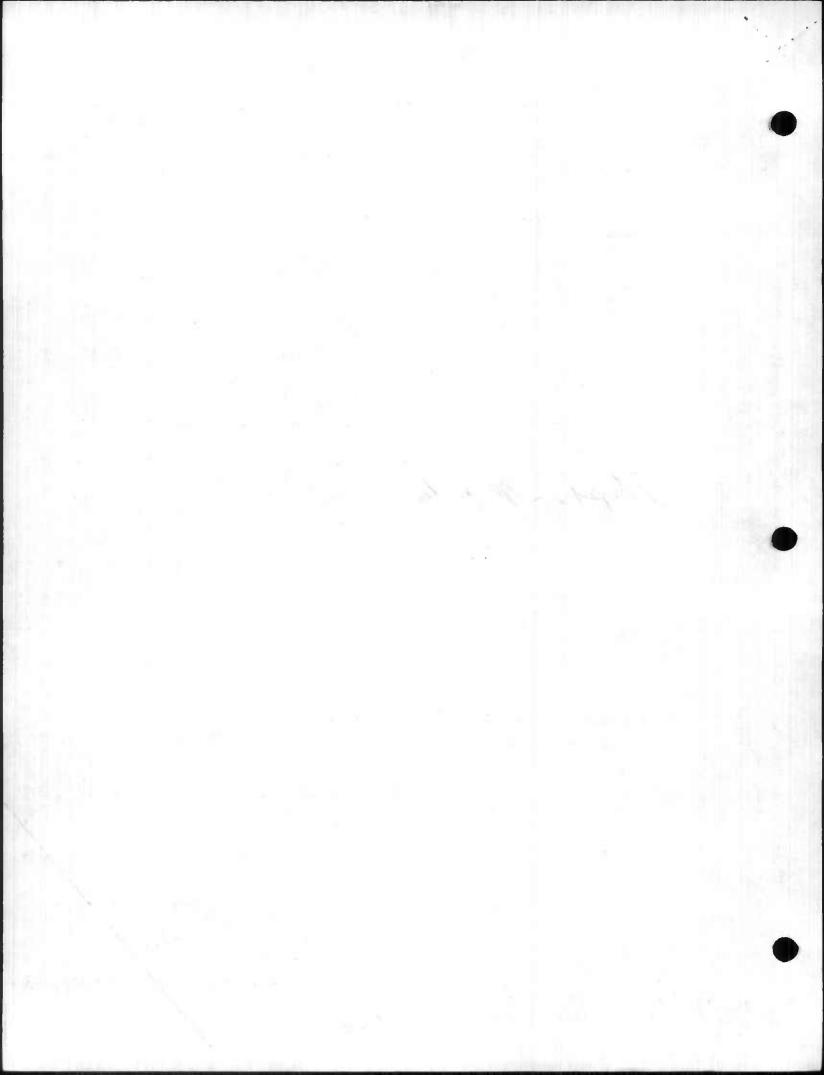
To the Vithin 2



## Pleas

e	Type or Print in Black Indelible Ink. Assure All Copies Are Legible.	11
	State of Maryland / Department of Health and Mental Hygiene	

Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** Julia Dollard E. 24, 1999 3:10 AM May /Medical 4e Fecility Nama (if not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crofton Convelescent Center Crofton Anne Arundel If Under 1 Yaar | If Under 24 Hrs. | Birthplaca (Steta or Foreign Country) 5. Sociel Sacurity Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** Months Days Hours 1 □ M 2 🖾 F Jan. 4, Director 214-24-2827 1915 Maryland Usual Residence of Decedant 10a State 10b. County 10c City Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2X No Director Maryland Queen Annes Stevensville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 202 Wallman Way natural, or hams 23s 21666 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Rece - Amarican Indian, 11 Merital Status Black, White, atc. filed within 72 hours after 1 Never Married 2 N Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☒ No Specify: by 3 Widowed 4 Divorced Yaar or Datas: White Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygiera Important: If Nem 27 is marked other the any Injury or other traumatic event state once. 12 Clothing Manager Sam's Discount Store 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Be George M. Reynolds E. Cora Hymitter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 202 Wallman Way Mr. John George Dollard Stevensville, MD 20b. Place of Disposition (Nama of cematary, cramatory or other place) Data 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 Donation 5 Othar (Specify) 5/27 Springfield Cemetery Sykesville, Maryland 21. Signature of Fuperal Service Libensee 22. Nama and Addrass of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133 23a. Part1. Enter the disaasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediata Causa (Finel arkinsenism disaasa or condition rasulting in death) 5 years **Examiner** Dua to (or as a consequence of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Ceuse (Disaasa or Injury that initiated events resulting in death) Lest Dua to (or as a consequence of) P.O. Box 68760. Physician/Medical Dua to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 TNo 3 Probably 4 Unknown Hy pothy roedym signed l Records. ģ 24b. Were autopsy findings aveilable prior to completion of cause of death? page 2 should Completed 24a. Was an autopsy 1 Yas 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attanding Physician: funeral director, Be 25. Was casa raferred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No hours after death. investigation 2 Accidant 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicide 24 hours a 29e. Certifiar 1 Certifying Physician: To tha best of my knowledge, deeth occurred at tha tima, deta and place, and dua to tha causa(s) and mannar as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Within 2 29b. Signature and title of contiller 29c. Licensa number 29d. Date signed (Month, Day, Year) 38-9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANNAPOLIS ROAD #106 ODENTON MD21113 SINGH DALTEET SIDHU 1413 31. Data tiled (Month, Day, Year) 32. Registrer's Signatura State MAY 2 7 1999 Registrar

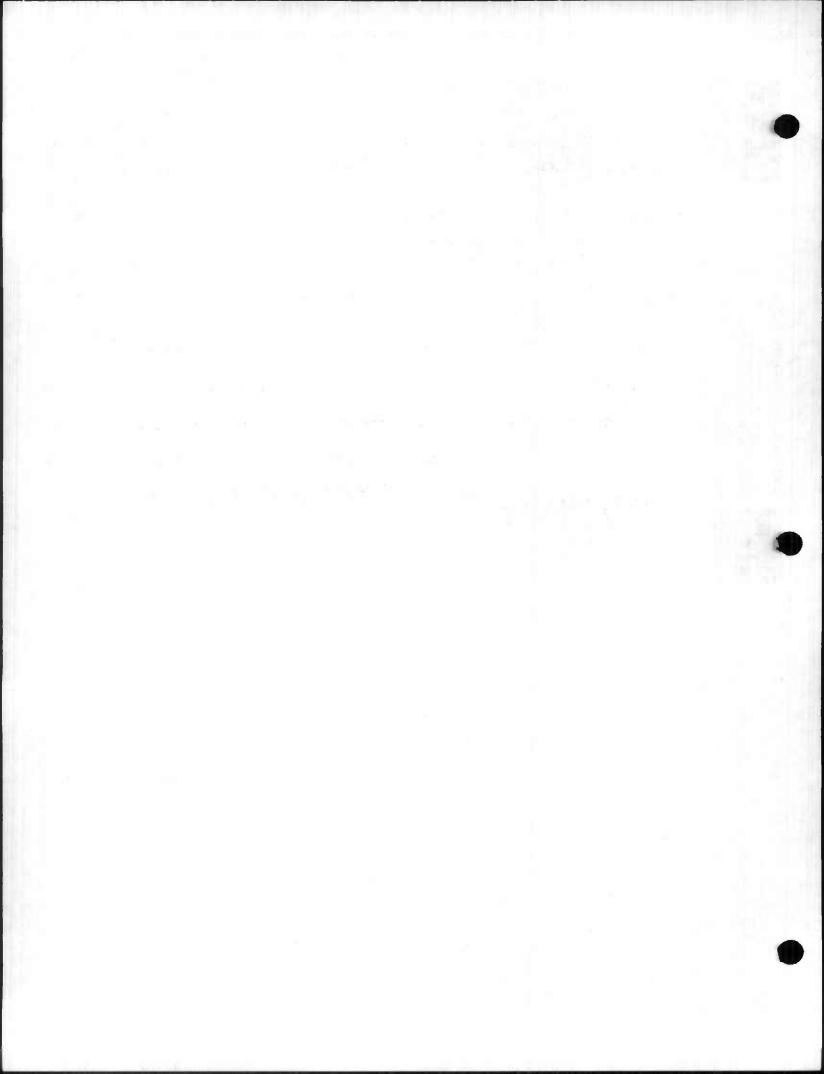


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Neme (First, Middle, Lest) 2. Dete of Deeth 3. Time of Death **Physician** Wilbur Vans 2:36 PM /Medical 4e. Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Baltimore Baltimore Neswick multicare Center 8. Dete of Birth (Month, Dey, Ye 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs.

Months Deys Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** XXM 2 F Deys Director 215-01-1326 94 Yrs. 1904 Maryland Usuel Rasidence of Decedent deeth with the Marylend 10a State 10b. County 10c. City, Town or Location show 10d. Inside City Limits 7 is marked other than "naturel", or items 23a or 28a-f shot traumatic event, the Medical Examiner must be notified at Maryland N/A Director XXYas 2□No Baltimore 10e. Street end Number Keswick Multicare Center 10f. Zip Code 10g. Citizan of What Country? 700 W. 40th Street Completed by Funeral 21211 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status 14. Race - American Indian, Bleck. White, etc. filed within 72 hours effer 1 Never Married 2 Married 21215-0020 1 ☐ Yes XX No Specify: white Widowed 4 Divorced Specify: 16e. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry General Supply & Elementery/Secondary (0-12) end Mental Hygiene. Coilege (1-4or 5+) Clerk Equipment Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Pages 1 end 2 should be Rev. George W. Evans Laura Harrison 19e. Informent's Name/Raietionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Coda) permit. Pages 1 end 2 s Department of Heelth or Important: if item 27 is any injury or other trau once. John A. Hoover Cousin 5 Turtle Rock Court Baltimore, Maryland 21234 Baltimore, 20e. Method of Disposition
1 D Burial 2 □ Cremetion 3 □ Removel from State 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete Druid Ridge Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 5/29/99 Pikesville, Maryland 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc
3631 Falls Road Baltimore, Maryland 21211 21. Signature of Funeral Service bicensee Part 1. Enter the Assault of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart/ailure. List only one cause on each lina. **Physician** /Medical Immediata Cause (Fine) I Schim.c CARD. UMTO PATHY 2725 diseese or condition resulting in daath) Examiner Dua to (or es a consequence of) Examiner Y 65 CARSOLORCEURA The law requires that the death certificete be executed the buriel-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury and Due to (or es e consequence of): P.O. Box 68760, attending physician Physician/Medical that initieted evants resulting In deeth) Last Due to (or es a consequence of): USB as Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? certificate has been signed by the irector, page 2 should be detached 1⊠Yee 2□ No 3□ Probably 4□ Unknown RECENT MICCORDING INFANCT (4/95) Division of Vital Records. þ Completed 24e. Wes en eutopsy performed? 24b. Were eutopsy findings evailable prior to completion of causa of daath? ATTHOR F. Bannon (4/91) CUTS 1 ☐ Yes 2 No 1 ☐ Yes 2 No Physicien: Be 25. Wes case referred to medical 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Rasidence 8 Other (Specify) P 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death Date of Injury (Month, Dey Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After or Attending 5 Pending investigation 1 Naturel death. 1 Yes 2 No 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be detarmined 3 Suicida 28a. Ptaca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 - Homlcide Hospital edicai 1 Certifying Physician: To the best of my knowledga, daath occurred et tha time, dete end place, end due to tha cause(s) and manner es steted.
2 Medical Examinar: On the bests of examination end/or investigation, in my opinion, daath occurred et the time, date end place, and due to the cause(s) end manner stated. (Check only one) the th 29b. Signeture end title of court 29c. License number 29d. Dete signed (Month, Day, Yeer) 1) 12399 MAY 26, 1999 30. Name and eddrass of person who completed cause of deeth (Item 23e) (Type, Print) 700 W. 40MST CHALLES m CHONOMAD IS KESWICK BALT. MILE M) 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State Registrar



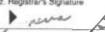
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month 3. Time of Deeth **Physician** Sa llie ·30 PM MOIC /Medical 4c. County of De 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner Baltmore
If Under 1 Year If Under 24 Hrs. 8. Date Irvington Knoll 5. Social Security Number 7. Age (In yrs. last birthday) Birthpiece (State or Foreign Country) **Funeral** 219-32-8530 1□ M 2DE Deys Yrs. Director 3 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23e or 28a-f show traumatic event, the Madical Examiner must be motified at Ba Himore Director 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3402 Avenue "natural", or items 23e 15 e 212 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give 11. Maritel Stetus Race - American Indian, Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1□ Yes 2D No Specify: by Specify: Black 3 ☐ Widowed 4 ☑ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Unic Elementery/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. marked other than rimmer 17. Fether's Neme (First, Middle, Last) permit. Pages 1 end 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked oth any Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Sumeme) 1101a 10cmes Juncan, 19e. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Sister Bernice Car Balto, red 21216 3402 20b. Pleca of Disposition (Neme of pemetery, cremetory or other r 20a. Method of Disposition
1 X Burial 2 ☐ Cremetion 20c. Location - City or Town, Stete 3 ☐Removal from Stete 4 □ Donation 5 □ Other (Specify) 21. Signeture of Funeral Service Licenses Balto, red 21215 Wabas 4300 repure rent1. Enter the disease, or complications that clused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear feiture. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel Corongry diseese or condition resulting in death) Examiner ettanding physician and for usa as the burial-transit The law requires that the death certificate be axecuted Physician/Medical Exami Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest Records, P.O. Box 68760, Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 3/2 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No by 9 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24a. Wes en eutopsy After this certificate has I funeral director, page 2 s Division of Vital or Attending Physician: Be 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 1 ☐ Yes 2 No Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deet 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 1 Naturel 2 Accident 5 Pending investigation To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 Yes 6 Could not be determined 3 ☐ Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

Medical Examinar: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end placa, end due to the cause(s) end menner stated. Medical (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year)

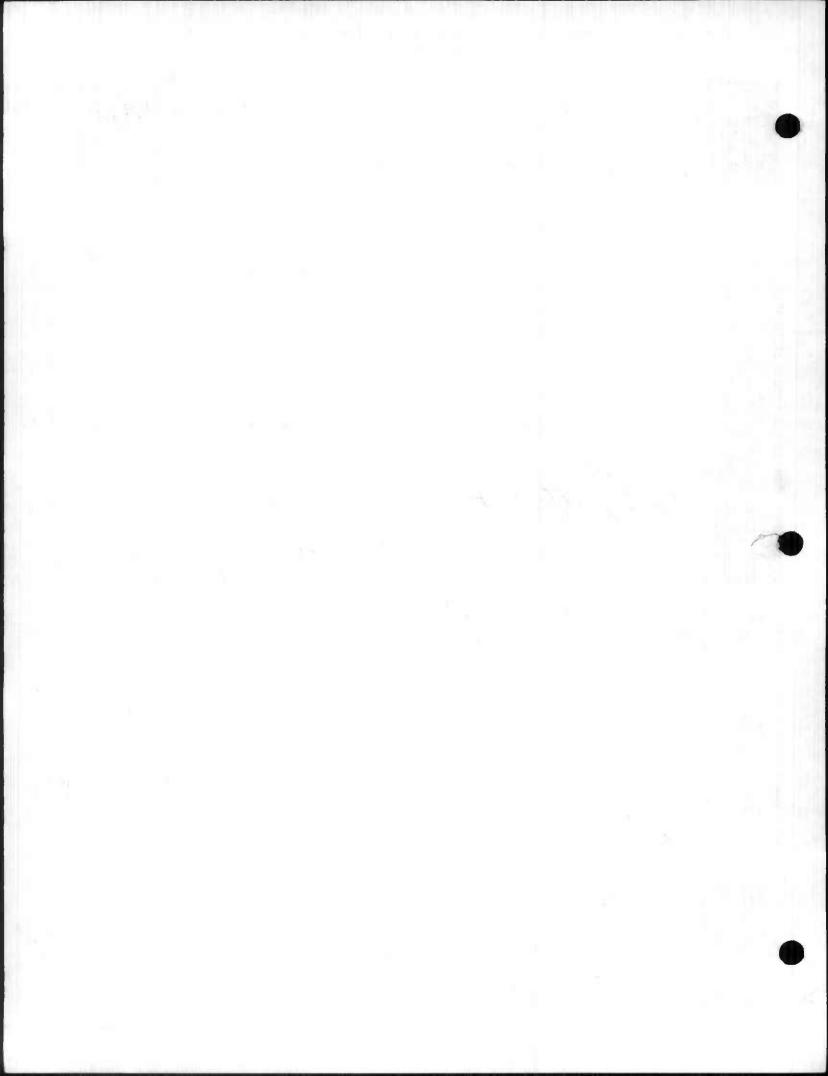
State Registrar

MAY 27 1999

31. Dete filed (Month, Day, Yeer)



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death 1999 **Physician** FINNERAN WILBUR J. 09:34 A MAY 16 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Courty General Hospital Howard Columbia If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 6. Sex Birthplace (Stata or Foreign Country) **Funeral** 100M 20 F Months Days Yrs. 220-24-3987 Director FEB. 24. 1930 Howard Usual Residence of Decedent ahow 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits ral', or items 23a or 28a-f ahov Examiner must be notified at MD Baltimore N/A 1 XYas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? 2417 Ashton Street permit. Pages 1 and 2 should be filed within 72 hours effer death 1. Department of Heelth and Mentel Hygiene. Important: If Itam 27 ie marked other than "natural", or frems 23a and Injury or other treumatic event, the Medical Examinat mass ence. 21223 USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 X Yes 2 □ No If Yas, Giva Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, White, atc. 1 Never Married 2 Married aitimore, Maryland 21215-0020 1 Yas 2 No Specify: white Specify: p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unknown Unknown Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumema) Be Wilbur Finneran 0 Sarah Taylor 19a. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores Ziegler - cousin 524 S. Catherine St., Balto., Md. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 5/<sub>21/99</sub> 20a. Method of Disposition 20c. Location - City or Town, Stata 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cemetery Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signalure of Furjeral Service Licenses 22. Nama and Addrass of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md.
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final diseasa or condition rasulting in death) FOREIGN BUDY ASPIRATION (FOOD) minutes Examiner Dua to (or as a consequence of) Examiner sician and burial-transit The law requires that the death certificets be executed Sequentially list conditions, if any, leading to immadiate ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or es a consequence of): P.O. Box 68760. Physician/Medical Dua lo (or as a consequence of): Part II. Other significant conditions contributing to death but not rasulting in the underlying ceusa given in Part I. 23b. Did tobacco usa contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown Chronic Obstructive Pulmonary Discuse, Schizophrenia Records. þ Completed 24a. Wes en eutopsy performed? 24b. Were autopsy findings available prior to Mostrake SIP @ hip hemiarThrocompletion of causa of death? 4/99 plasty 1 Yas 2 No 1 Yas 2 No certificate of Vitai or Attending Physician: 25. Was casa refarred to medicel 8 26. Placa of Deeth (Check only one) axaminer? 1 XYes 2 No Hospital: Other: 4 Nursing Home 5 Rasidenca 6 Othar (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? After (Month, Day Year) Injury

MAY 16, 1999 ~ 9 Division 5 Pending invastigation 1 Natural choked on food efter death. 1 TYas 2 DINO 2 Accident M 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 ☐ Homicide 3000 N. Ridge Rd, Elliatat home 24 hours e Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and manner as stated. 2 Aledical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the ŝ Dyng ME 29b. Signature and little of certifier 29c. License number 29d. Data signed (Month, Day, Year) May 24, 1999 mz aut -30. Name and address of person who complated callsa of death (Item 23a) (Type, Print) 4565 Hemlock Cone way Ellicott City MD 21042 PATRYCE A-TOYE WD 31. Data filed (Month, Day, Year) 32. Registrar's Signature

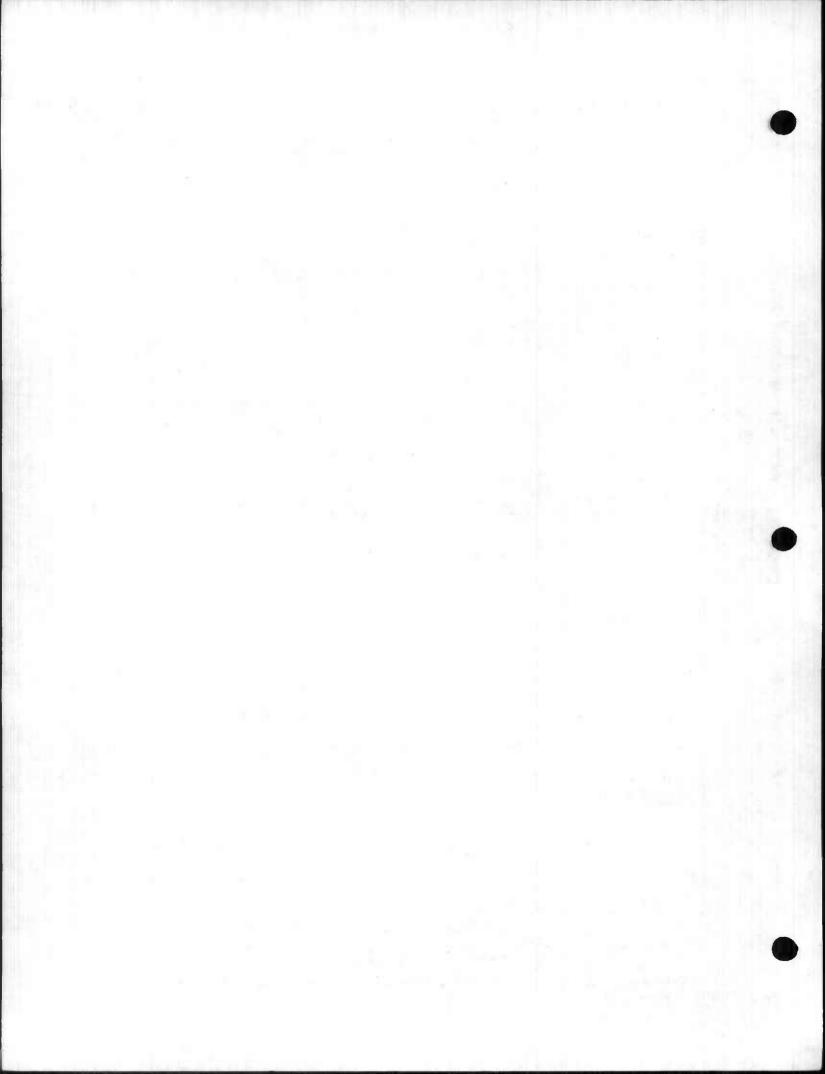
Registrar DHMH 16 Rev 6/95

State

MAY 27

1999

**ORIGINAL** 



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death May 21, Year 1999 Mary A. Germack 1:00 PM 4a. Facility Name (if not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Mariner Glen Burnie Glen Burnie Anne Arundel 5. Sociel Sacurity Number If Under 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 09/16/1905 9. Birthpleca (Stata or Foraign Country) West Virginia 7. Aga (In yrs. last birthday) 1□ M 2MF Deys 93 Yrs. 216-01-2901 Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Yas 2 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1362 Tri Water Court 21226 USA 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Yes 2 No If Yes, Give Yaer or Datas: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yas 2 No Specify: White 3 ■ Widowed 4 Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT usa ratired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grada completed) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Surname) Unknown Johnson Unknown 19e. informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code) Melvia Ann Hagan/Daughter 5611 Edmondson Ave. Baltimore, Maryland 21229 20e. Method of Disposition 20b. Pleca of Disposition (Name of cemetery, cremetory or other pleca) 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete WoodLawn Cemetery 5/25/99 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility David J. Weber Funeral Homes, P.A. 5311 Edmondson Ave. Baltimore, Maryland 21229 23a. Part1. Entar tha disease, or no policetions that caused the deeth. Do not enter the mode of dying, such es cardlec or respiratory arrest, shock, or heart feilure. List only ona causa on each line. Approximeta Interval Between Onsat end Death FAILURE immediata Ceusa (Final disaasa or condition rasulting in death) Sequantielly list conditions, if eny, laading to immediate cause. Enter Underlying Ceuse (Diseasa or Injury that initieted evants resulting in death) Lest Due to (or as e consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to daeth but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes (2) No 3 Probably 4 Unknown O EM ENTIA 24b. Were eutopsy findings aveileble prior to 24e. Was en eutopsy performad? completion of cause of deeth? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 26. Piece of Deeth (Check only ona) Other: 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 🏖 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mannar of Death 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending Invastigation Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be datermined 28e. Plece of Injury - At home, ferm, straat, factory, office building, atc. (Specify) 3 ☐ Suicide 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 4 Homicida Certifying Physician: To the bast of my knowledge, deeth occurred et the time, data and plece, end due to the ceuse(s) end mennar as stated.

2 Medical Examinar: On the basis of exemination and/or investigation, in my opinion, death occurred et the time, date end plece, end due to the ceuse(s) and menner steted. 29e. Certifier (Check only one)

The law requires that the death cartificate be asscuted Division of Vital Records, P.O. Box 68760, or Attanding Physician:

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

Directo

Funeral

þ

Completed

Be

7 is marked other than "natural", or flams 23a or 28a-f shot traumatic event, the Modical Examination ust be notified at

permit. Pagas 1 and 2 should be lile Department of Haelth and Mental Hy Important: If frem 27 is marked othe any injury or other traumatic event, once.

**Physician** 

/Medical

Examiner

signed by t

Aftar this certificata

within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral.

Physician/Medical

by

Completed

Be

2

Certification:

edical

lijed within 72 hours aftar death with Hygiana.

Baltimore, Maryland 21215-0020

tha Maryland

**DHMH 16 Rev 6/95** 

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State Registrar

31. Dete filed (Month, Day, Yaar)

30. Nema end

29b. Signatura and title of certifiar

DOM OND

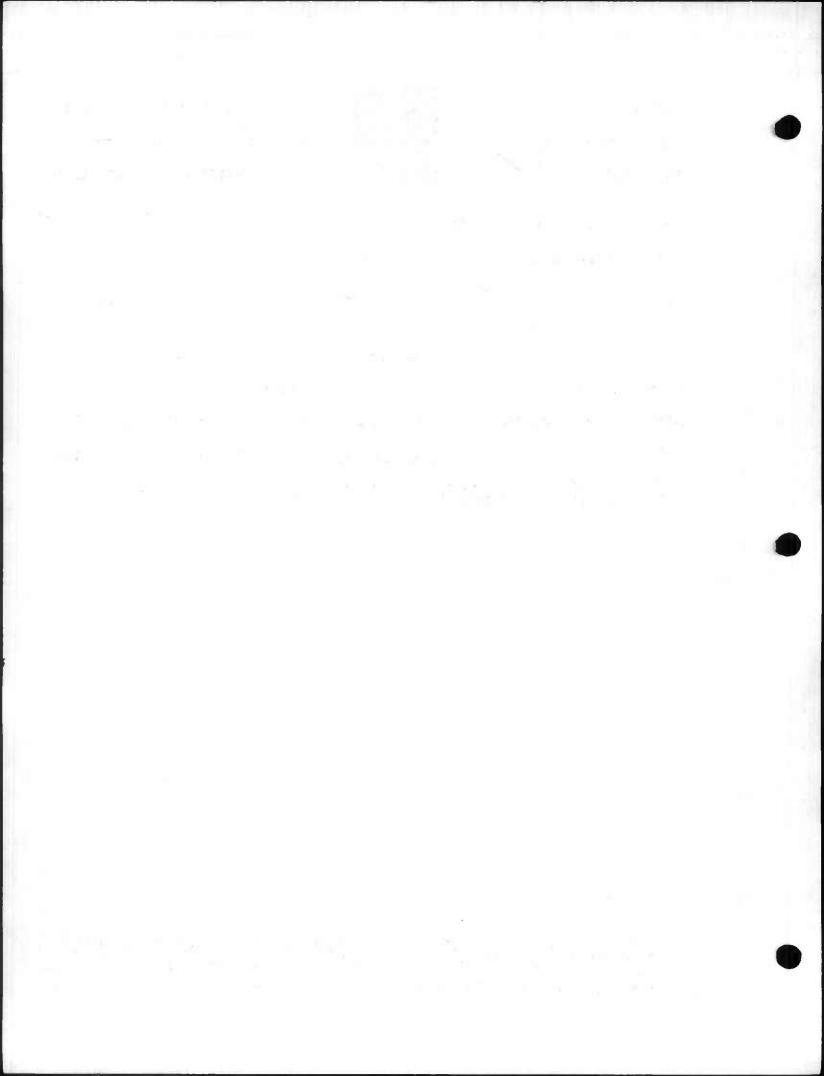
dress of person

APZA 32. Ragistrar's Signature

completed cause of deeth (Item 29a) (Type, Print)

29d. Dete signed (Month, Day, Year)

GREEN



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Man **Physician** HawKs Barbara 6:30 a.M /Medical 4c/County of Death 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death **Examiner** Baltimore KegesTer 720 8. Dete of Birth 7. Age (in yrs. lest birthday) 37 Yrs. If Under 1 Year If Under 24 Hrs. nplece (Stete or Foreign 5. Sociel Security Number 9. Birth **Funeral** Days 1□ M 2 F 220-80-246 9 Usuel Residence of Decedent Director 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits 7 is marked other than "natural", or thems 23s or 28s-f shor traumatic event, the Medical Examiner must be notified as Baltimor 1 BYes 2 No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours efter death with nent of Health and Mentel Hygiene. USA 1720 12 Funeral 11. Maritei Stetus 12. Was Decedent Ever in U.S. Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American indien. Armed Forces? Bieck, White, etc. 1 Never Merried 2 W Married 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Baltimore Elementery/Secondary (0-12) College (1-4or 5+) Care Assistant Childrens 12th Grade 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Fether's Neme (First, Middle, Last) Wisdom 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. informent's Neme/Reletionship (Type, Print) permit. Pages 1 end 2 s Department of Health er Important: if item 27 ie any injury or other trau Baltimore 1720 25/1e Hawk 5-Mary 20b. Plece of Disposition (Neme of 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 Buriel 2 □ Cremetion 3 □ Removel from State Men, 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility KeVin 21. Signeture of Funeral Service Licenses 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Intervel Between Onset and Deeth **Physician** /Medical immediete Cause (Finel disease or condition resulting in death) **Examiner** Due to (or es e consequence of) Examiner and I-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): ettending physician a for use as the buriel-Physician/Medical Due to (or es a consequence of): Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobecco use contribute to the cause of death? been signed by the should be detached 1 Yes 2 No 3 Probably 4 Unknown p 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Wes an eutopsy After this certificete hes funeral director, page 2 25 NO 1 Yes 1 ☐ Yes BØ No Hospital or Attending Physician: 24 hours efter deeth. Funeral Director: After this certifice stely filled in by the funeral director, p. Be 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home SX Residence 6 Other (Specify) Certification: To 1 Yes 2√No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of injury (Month, Dey Year) 27. Menner of Deetl 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Neturei 2 ☐ Accident 5 Pending investigation 1 Yes 2 🗌 No 3 Sulcide 6 Could not be To the Hospital or Atte within 24 hours effer de To the Funeral Directo completely filled in by th 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end manner as steted.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end plece, and due to the ceuse(s) end menner steted. 29a. Certifier edical 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

State Registrar

DHMH 16 Rev 6/95

the Marylend

altimore, Maryland 21215-0020

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

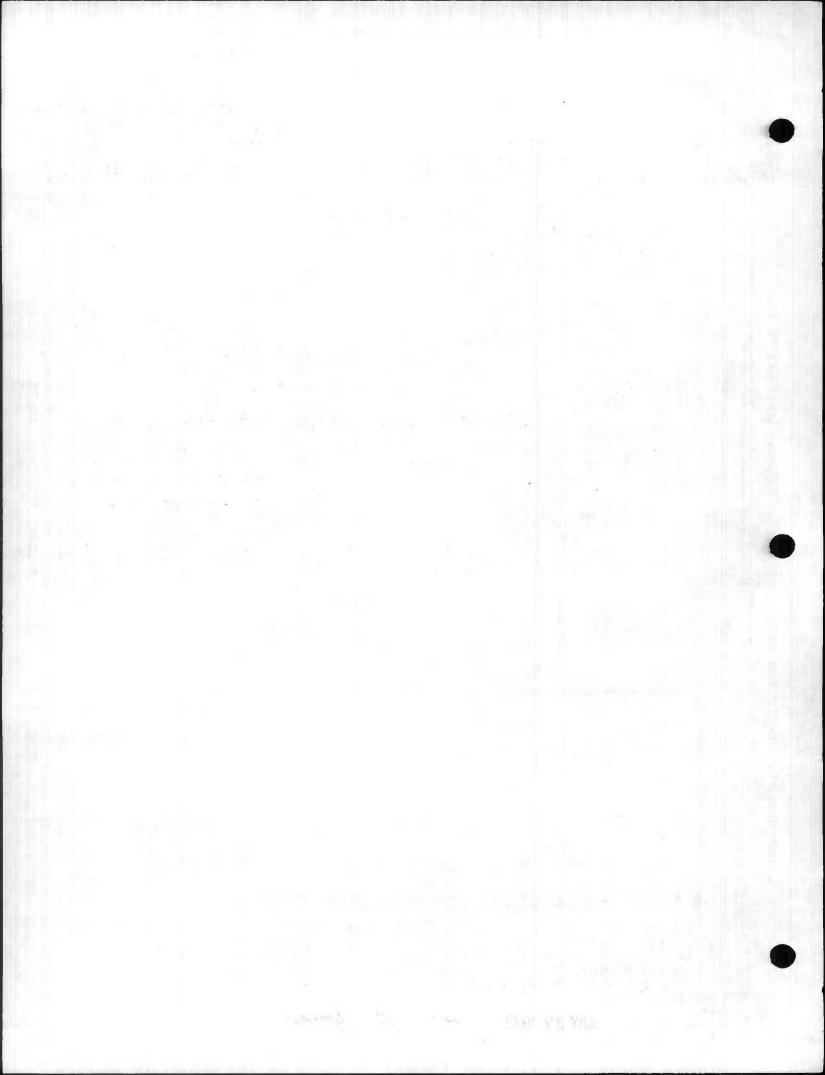
32. Registrer's Signeture

address of person who completed cause of deeth (Item 23e) (Type, Print) 1447

OVK

COPERMO

31. Dete filed (Month, Dey, Year)



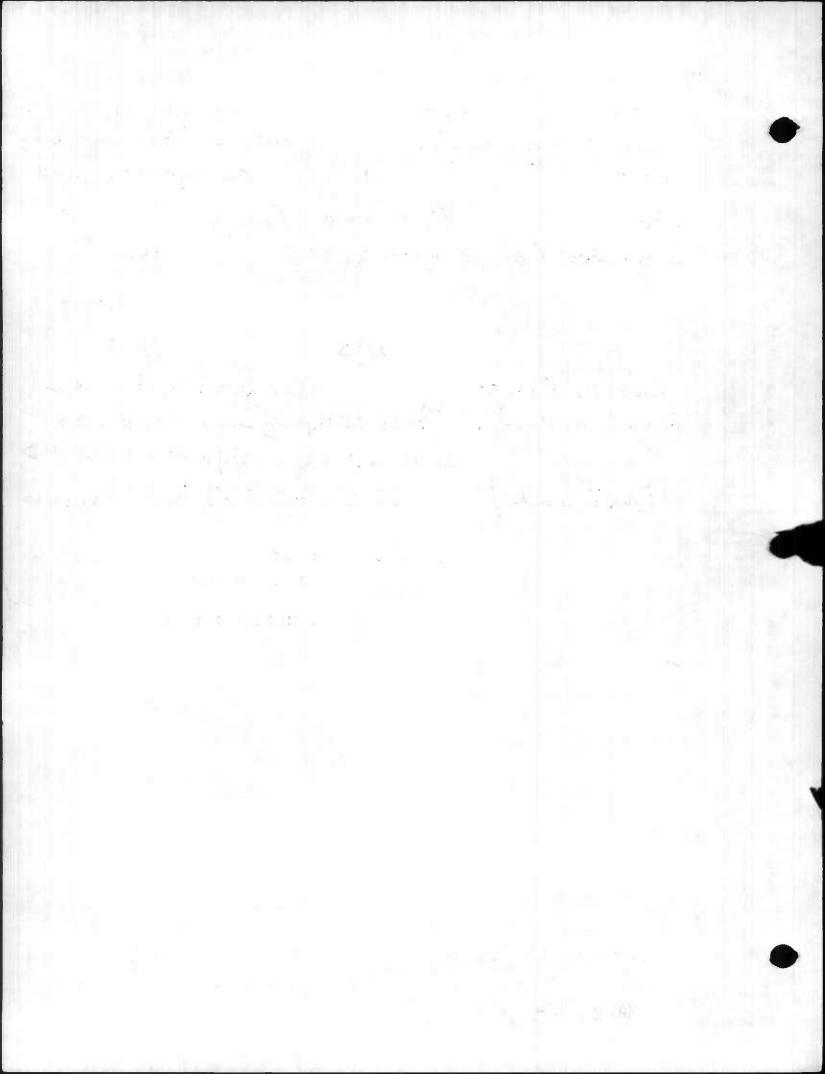
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND\_ITEM#23a per phy. 6771 5-27-99 j.a 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Day **Physician** 5:25 PM Khary SOM Fe by4 /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Baltimore Baltimore Hopkins Johns -05 oita If Under 24 Hrs. 8. Deta of Birth
Month, Day, Year) 5. Social Security Number If Undar 1 Yaer 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign 6. Sex **Funeral** 10M 20 F Months Deys Director 1991 Mary none January Usuel Rasidance of Decedant permit. Peges 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hydene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, in Medical Examiner must be notified at once. 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 as 2 No Director more 6 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? USA ldsprina Des ane 2 0 Funeral 12. Was Decedent Ever in U.S. Was Decedant of Hispenic Origin? (Specify Yas or No-tif Yes, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amarican Indien, 11. Marital Status Armed Forcas? Black, Whita, etc. 1 Never Merried 2 Marriad 1 Yas 20 No Baltimore, Maryland 21215-0020 tf Yas, Giva Yaar or Datas: Specify: þ ack 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Dacedent's Educetion (Specify only highest grade completed) Elamantary/Secondary (0-12) College (1-4or 5+) 18. Mothar's Nama (First, Middle, Meiden Surneme) 17. Fathar's Nama (First, Middle, Last) Be -arlo Mase sta utchinson 19a. Informant's Name/Ralationship (Type, Print) Grand for State, Zip Code) Hutchinson 2435 W. Coldspring Balton Kona 21215 Lane 10 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Deuriel 2 Crametion 3 Removel from State Randallstown, MD 2/13 Memorial Park 4 ☐ Donation 5 ☐ Othar (Specify) Kina 21. Signature of Funaral Sarvice Licansaa 22. Nama and Addrass of Fecility Gary P. March Funeral Home P.A. 270 Fredhilton Pass Baltimore, MD. 21229 23e. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximeta Intervat Between Onset and Death **Physician** /Medical Immediata Causa (Final BRAIN DEATH disaasa or condition rasulting in daath) POXIA Examiner CARDIOPULMONARY ARREST Examiner days The law requires that the death certificate be executed ettending physician end for use es the bunel-transit Sequentielly list conditions, if any, laading to immadiata causa. Entar Undartying Cause (Disaasa or injury that initielad avents resulting In daeth) Last Dua to (or as a consequence of) CONGIENTAL HEART DISEASE Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequanca of): ed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa givan in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed to þ 24b. Ware autopsy findings evallable prior to complation of ceuse of death? should l 24a. Wes an autopsy performed? Completed s certificate hes b director, page 2 s 28 No 1 Yas 2 No or Attending Physician: director, Be 25. Was cesa referred to medical axaminar? 26. Placa of Death (Check only one) 10 1 Yas 2 No 1. Inpatiant Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this funeral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Time of Certification: 28c. Injury at Work? : After 1 5 Panding invastigation 1 Natural 1 ☐ Yas 2 ☐ No death. Director: A 2 Accident 6 Could not be determined 3 ☐ Sulcida Location (Street end Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) on 24 hours
the Funeral Directory 4 Homicide 12 Certifying Physician: To the best of my knowledge, daath occurred at tha tima, data and place, and dua to tha ceusa(s) and manner es stated.
2 Medical Examiner: On the basis of axamination and/or invastigetion, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and menner steted. 29a. Cartifiar edicai completely (Check only one) within 2 To the 29b. Signatura and title of certifian 29c. Licansa number 29d. Data signed (Month, Day, Year) 0 MID Ph

State Registrar 30. Nama and addrass of person who completed causa of deeth (Item 23e) (Type, Print) Gruber

31. Data fliad (Month, Day, Year) 999

2 7 mD, Phi

32 Ragistrar's Signatura



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth Day 26 Month 7:30 An 99 Larry D. Hall 4b. City, Town, or Location of Death 4e Facility Neme (If not Institution, give street end number) 4c. County of Death Linthicum If Under 24 Hrs. 8. Da Hours Min. (M Hospice of the Chesapeake Anne Arundel If Under 1 Year 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dev. Year) Birthplace (State or Foreign Country) 18 M 2□ F Months Deys Yrs. 236-66-2580 58 Jan. 20,1941 West Virginia Usual Residence of Decedent 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 M No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7896 Pepperbox Lane U.S.A. 21122 12. Wes Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No 1962if Yes, Give Yeer or Detes: 1965 Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indian Bleck, White, etc. 1 ☐ Never Married 2 M Merried 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 1965 White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 12 Manager 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Maynard Davis Hall Thelma Ruth Sutton 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Patricia L. Hall (Wife) 7896 Pepperbox Lane Pasadena, Maryland 21122 20e. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, Stete Date 1 ☐ Burial 2 ☐ Cremetion 3 K Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Miller Cemetery 5/29/99 Webster Springs W.Va. 22. Name end Address of Fecility 21. Signeture of Funeral Service Licensee McCully-Polyniak Funeral Home P.A. 3204 Mountain Road Pasadena, Maryland 21122 7 23a. Part I inter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Ceuse (Finel disease or condition resulting in deeth) Gladder cancer metastate Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Disease or injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es a consequenca of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 2 NO 1 Yes 1 ☐ Yes 2 No 25. Wes case referred to medical 26. Place of Death (Check only one)

Physician /Medical Examiner

requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

**Physician** 

/Medical

Examiner

Directo

Funeral

þ

Completed

**Funeral** 

Director

7 is marked other than "naturel", or items 23s or 28s-f show traumstic event, the Madical Examiner must be notified at

the Maryland

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deeth

permit. Pages 1 and 2 should be filed within 72 hours effer of Depertment of Health and Mental Hygiene. Important: If item 27 is merked other than "naturel", or harmals.

Baltimore, Maryland 21215-0020

Examiner physician and the buriel-transit Physician/Medical the 88 USB signed by the at d be detached for by Completed page 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director, Be Certification: To

has

certificata

28e. Dete of Injury (Month, Dey Year)

Other: 4 Nursing Home 5 Residence 6 Nother (Specify) hospice 28d. Describe how injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, State) 15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) and manner es steted.

2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29b. Signeture and title of certifier

5 Pending Investigation

6 Could not be determined

1 ☐ Yes 20 No

27. Manner of Deeth

1 Neturel

2 Accident 3 Suicide

4 ☐ Homicide

29a. Certifier

29c. License number 022782

28c. Injury et Work?

1 ☐ Yes

29d. Date signed (Month, Dey, Year) May 26, 1995

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

5. Hanover St, Baltimare, Md. 21230 erkman 3001 MO 32. negistrer's Signature

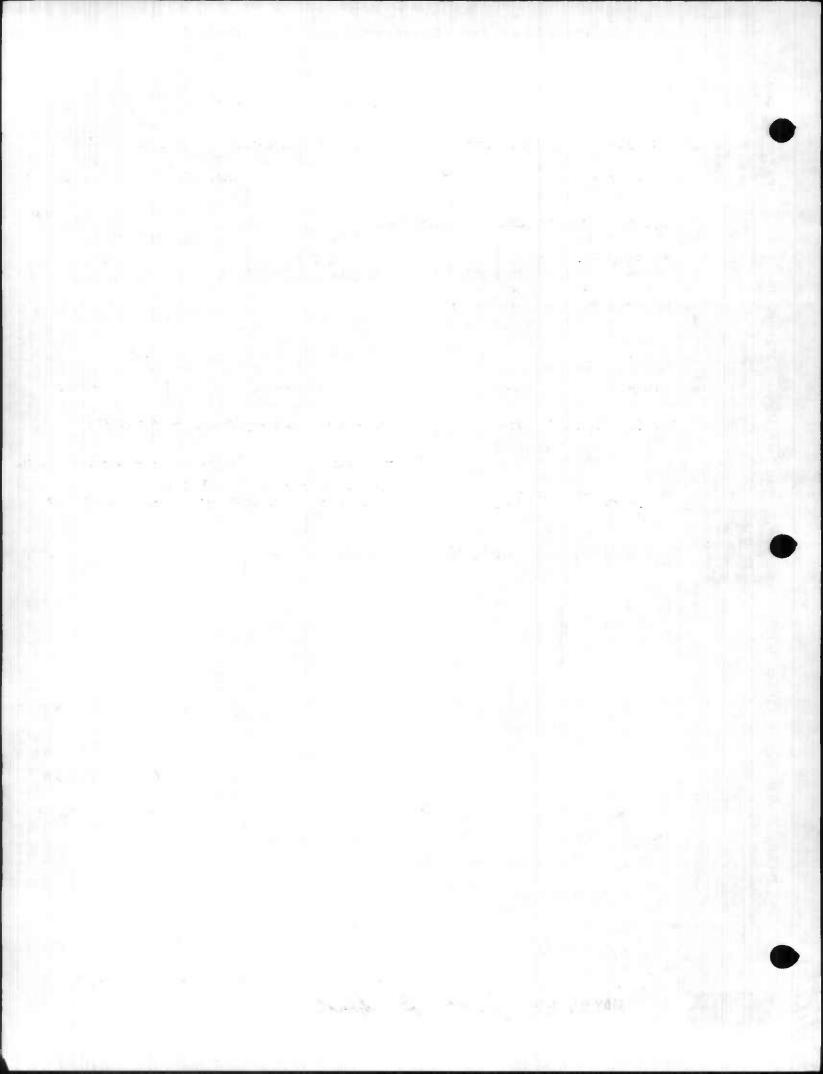
1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

State Registrar

edical



AHO

21215-0020

altimore, Maryland

Box 68760.

Records,

Division of Vital

DHMH 16 Rev 6/95

State Registrar 30. Name and address of person who completed can Mitchell Schwartz, M.D.

MAY 27 1999

31. Date filed (Month, Day, Year)

32. Registrar's Signeture

death (Item 23a) (Type, Print)

ORIGINAL

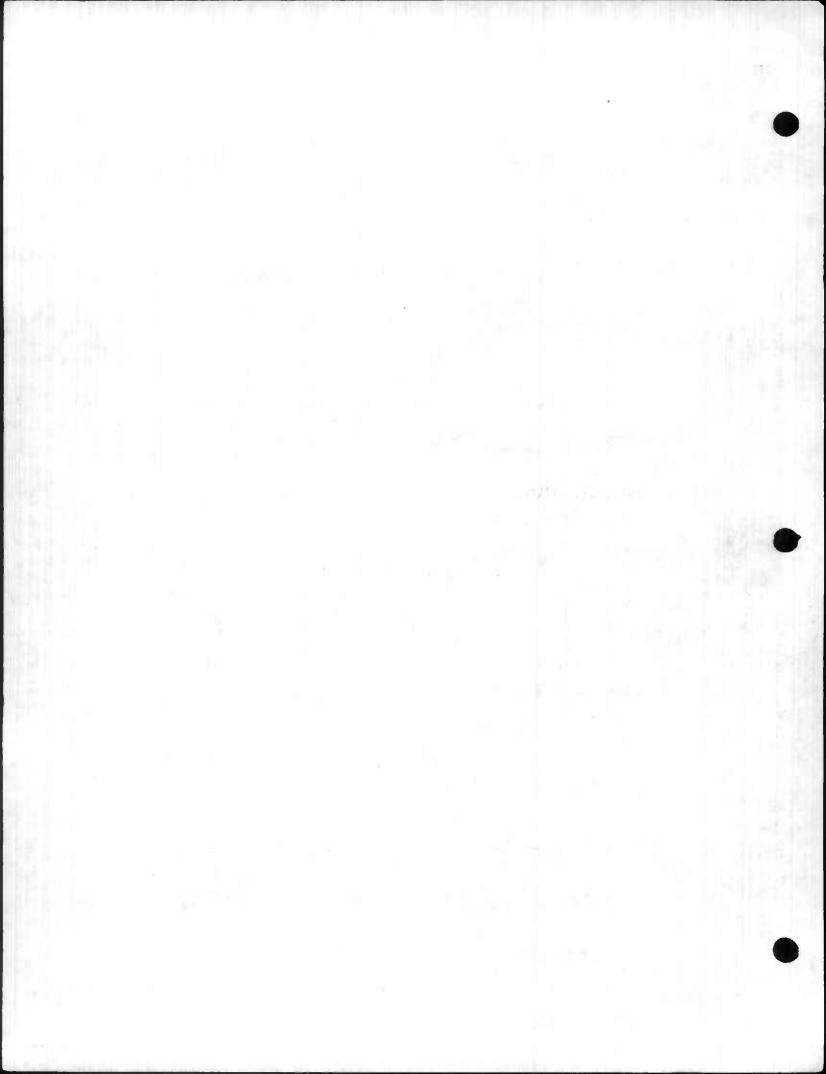
6569 N. Charles St.

D 44728

May 24, 1999

21204

Suite 407 Towson, MD



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. B.K.S State of Maryland / Department of Health and Mental Hygiene JEREMY THOMAS HENRY Amended Item#5 perFH G772 6/28/9 Gentificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 1999 Year **Physician** MAY 23, Jeremiah Thomas Henry 2000 PM /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SHADY GROVE HOSPITAL E.R. ROCKVILLE MONTGOMERY If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 F Months Hours 568-61-6437 6137 20 Director AUG. 29, 1978 Germany Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits shoe 1 ☐ Yes 2 ☑ No Gwinnett Directo Georgia Lawrenceville 28a-f 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? ò 1532 Sir Knights Way 23e 30045 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status hours after 1 Never Merried 2 Merried 1 ☐ Yes 2 X No If Yes, Give 8 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry filed within 72 Elementary/Secondary (0-12) College (1-4or 5+) Never employed N/A altimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) å Pages 1 and 2 should be nent of Health and Mental David P. Henry Linda Jean Foster 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) out of Health a vot of Yor of David P. Henry - father 1532 Sir Knights Way, Lawrenceville, Georgia 30045 20b. Place of Disposition (Name of cemetery, cremetery or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 5/<sub>27/99</sub> 1 Burlel 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Pinecrest Cemetery Jessup, Georgia Cary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. uzon 21075 tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or es e consequence of) Box 68760 Physician/Medical the Due to (or as e consequence of): 980 signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 3 Probably 4 Unknown 1 Yes Records, by Completed 24b. Were autopsy tindings available prior to completion of cause of death? page 2 should 24a. Was an autopsy performed? 2 No Yes 2□ No certificate Division of Vital Attending Physician: Be 25. Wes case referred to medical 26. Place of Death (Check only one) TXXYes 2□ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ RR/Outpatient 3 ☐ DOA this funeral Date of Injury (Menth, Day Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? scribe how willing occurred 1 Natural 5 Pending 28e. Fileca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) death. 1 ☐ Yes 207 No Investigation 2 Accident Hospital or Attend
 24 hours after death
 Funeral Director: / Country (Street and Number or Rural Route Number, City or Town, State) 70 6 Could not be determined Suicide filled in by Feetville 10lucks 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner steted. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Sigry O.C.M.E MAY 24, 1999

State Registrar

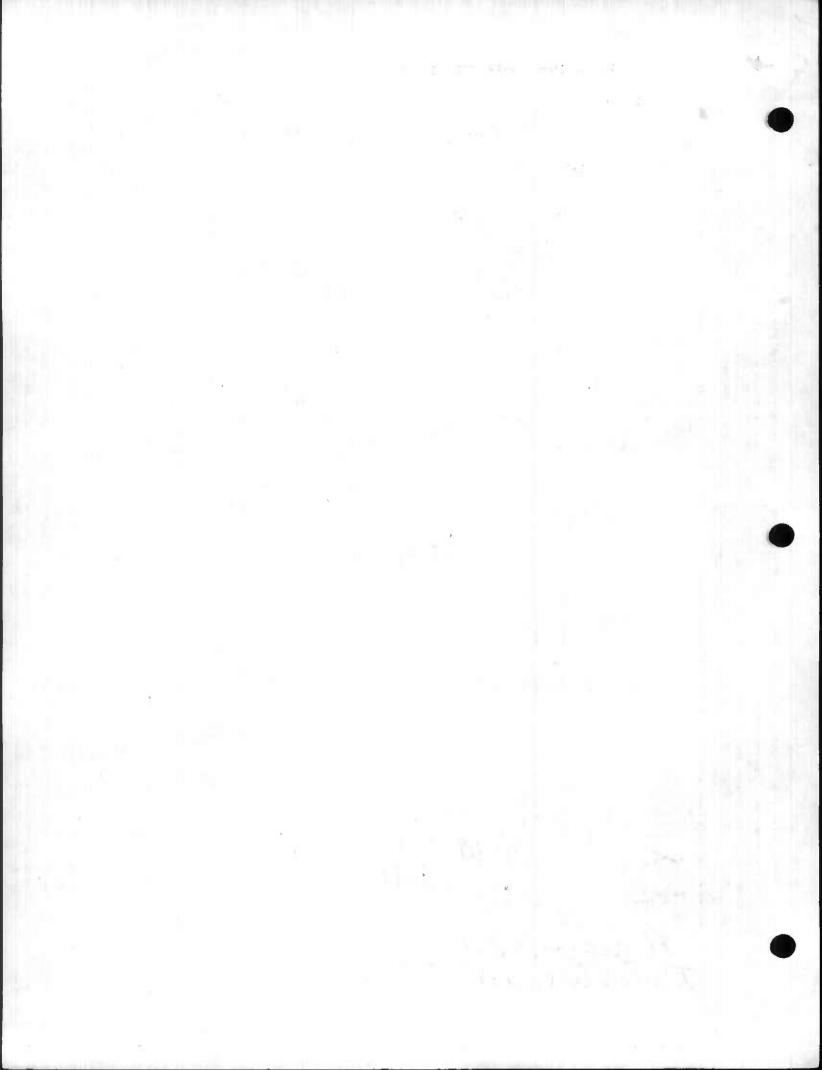
31. Dete filed (Month, Dey, Year)

MAY 27 1999

32. Registrar's Signeture

who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM: #18 PER F.H. G788 10-20-00 WR. Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Month **Physician** Louise 1999 May 26, 9:25a.m. Harris Margaret /Medical 4a Facility Nama (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner #5 Spinners Court A Apt Randallstown Baltimore If Under 1 Year 5. Social Security Number If Under 24 Hrs. 7. Aga (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days Months 1 ☐ M 2 🔀 F Yrs. Director 228-20-7520 73 16, 1925 Virginia Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Directo Maryland Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? #5 Spinners Court Apt 21133 Α U.S.A. Funeral 12. Wes Decedent Evar in U,S. Armed Forces? 14. Race - American Indian, Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yas 2 ☒ No If Yes, Give 1 Never Merried 2 Married 1 Yes 2 No Specify Specify: ğ 3 ☐ Widowed 4 ☐ Divorced Yeer or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 -0-Dept of Assessment City of Baltimore 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ANNIE PEARL SHUMATE. 8 Willie Edward Carter Annie Shoemate 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Marcia Lee Ellwood 26 Chapel Towne Circle Perry Hall, MD 21236 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Washington Crem 5/28 Laurel , Maryland 21. Signature of Funerel Service Licensee 22. Name and Address of Facility Loring Byers Funeral Directors, Ind Randallstown, MD 21133-4784 8728 Liberty Road Juns 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or haert failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel 0 diseese or condition resulting in deeth) Examiner Examiner Sequentially list conditions, if eny, teeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events rasulting in death) Last Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobaccouse contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ NO 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pieca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29e. Certifier Medical 1 Conflying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) and menner steted.

The lew requires that the death certificate be axecuted Box 68760. 0 ۵ Records, of Vital Attending Physician: Division e Hospital or Attending 24 hours after death. e Funeral Director: Aft

280-7

ð must be 238

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filed within 72 hours after

Hygiana.

Pages 1 and 2 should be nent of Health and Mental

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signed by the atte

hes page 2 certificate

funaral director,

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completely

29b. Signature and title of cartifier

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To the Vithin 2

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After

21215-0020

altimore, Maryland

State Registrar DHMH 16 Rev 6/95

Robert B. Kroopnick 4000 Old Court Road MAY 2 7 32. Registrer's Signeture

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

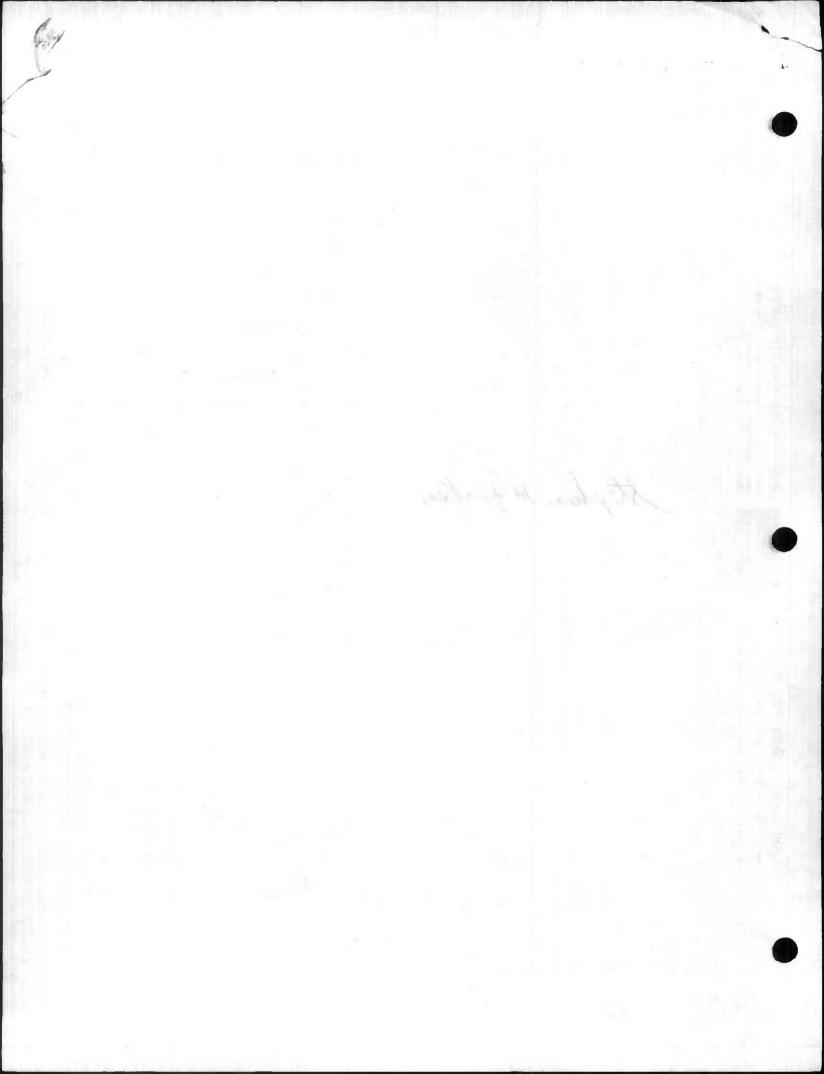
Pikesville, MD

29c. License number

29d. Date signed (Month, Dey, Year)

21208

9



Records, P.O. Box 68760, Division of Vitai

Baltimore, Maryland 21215-0020

29b. Signature and title of certifier amod

29c. License number

29d. Data signad (Month. Day, Year)

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

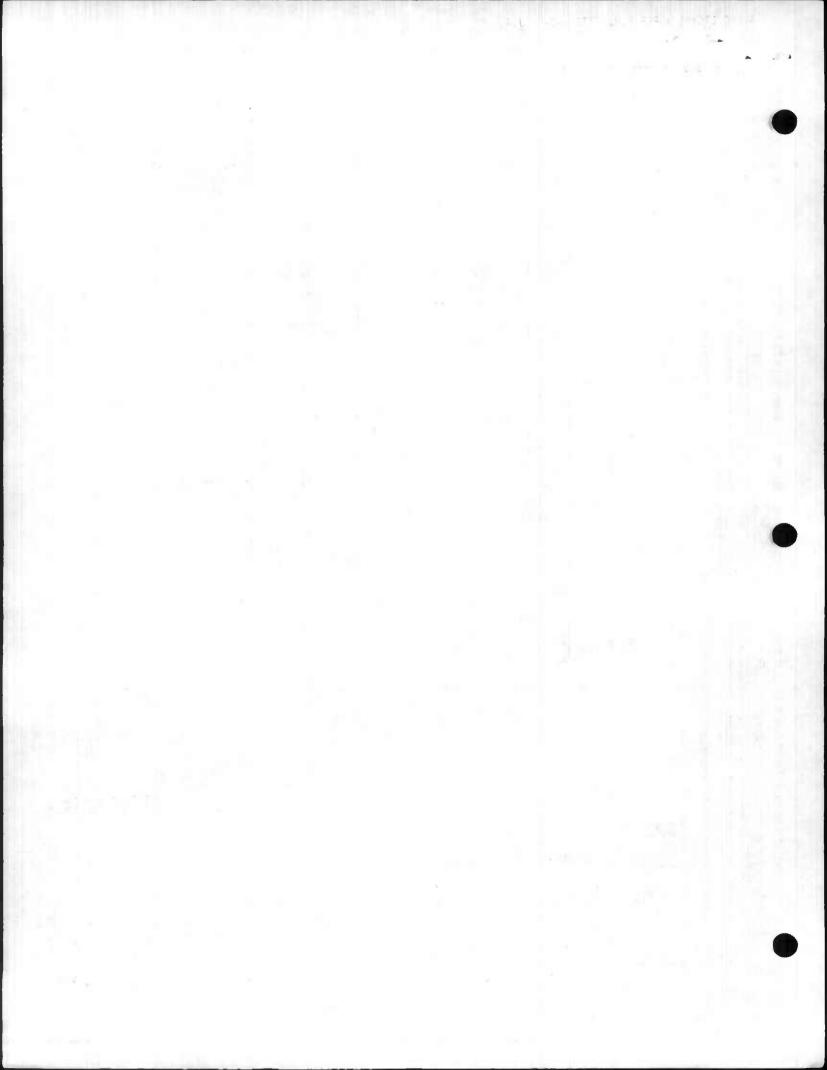
Francis X. Carmody, M.D.

7505 Osler Drive #212

Towson, Maryland

State Registrar 31. Date filed (Month, Day, Year) MAY 27





### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 17026

4 Descriptions				00/11/1	cate of				Reg. No.		
	ne (First, Middle, Las	(1)					2	Data of De Month	ath Day	-Year -	3. Time of Death
Ruth	DHI	lisbur	3				n	may.	25 19	799	10:30
	(If not institution, give	street and number,				4b. City, Tov			4c. County	of Death	
Howard	d Count	by Ge	nergi	HOSE	pital	COL	uml		HOV	war	d
5. Social Security N		0	ge (in yrs. last	Mo Mo	Under 1 Year		24 Hrs. 8 Min.	Data of Bir (Month, Da ay 28	th v. Year)	9. Birth	place (Stata or Fore
038-12-1	1230	□M 2∏F	71	Yrs.			M	ay 28	, 1927	New	York
Usual Residence o			T.O. O. T								
10a. Stata	10b. County			own or Locatio	n				1	10d. Inside City Lim	
FL 10e. Street and Nu	Colli	Ler	Nap1	es							1XXYas 2□1
10e. Street and Nu				10	Of. Zip Code				10g. Citizen of	What Cour	ntry?
	ama Circle	e #202			341	12			U.S.	Α.	
11. Marital Status		12. Was Decedent Armed Forces	Evar in U,S.	13. Was I	Decedent of	Hispanic Orig	gin? (Specia	y Yes or No	- 14. Rac	ce - Americ	
	ried 2 Married	1 ☐ Yas 2 ☑ If Yes, Give			ras 210 No		, 1 0010 11	an, etc.,			**
3 🖾 Widowed	4 Divorced	Year or Datas:		101	da ZAJIVO	эрвину.			Specif	y: v	hite
Elementary/Second 1 2 17. Father's Nama	15. Decedent's Ed	ucation	1	6a. Decedent's	S Usual Occu	pation	of working		16b. Kind of B	usiness/In	dustry
Elementary/Seco		College (1-4or	5+)			during most	o working				
12				Homema	aker				Own Ho	me	
17. Father's Nama	(First, Middle, Last)								Maiden Surnar	na)	
Carley	Henry					Edna	Fall	ows			
	lame/Relationship (7								er, City or Town		
Jacqueli	ine Lorton	Daughte	er	10096 F	Hat Br	im Ter	race,	Colum	nbia, MI	210	46
20a. Method of Dis	•		com/	of Disposition	(Nama of	ana)		Data	20c. Location	- City or To	own, Stata
	☐ Cremation 3 ☐ 5 ☐ Other (Specify			crest (			15/	29/99	Springf	blei:	Macc
	uneral Service Licens					ess of Facility	1		1 0		-
IN IN	0 4	00	/				WILZ	ke Fur	neral Ho	mes,	Inc.
10/4	ander I	Lem	ner						onsvill	.e, M	
shock, or hea	the disease, or comp art failure. List only o	plications that cause one cause on aach l	d the death. D ina.	o not entar the	a moda of dy	ing, such as o	cardiac or r	espiratory a	rrest,		Approximate tntarval Between
											Onset end Deeth
Immediate Cause disease or condition	non	a Cond	racer	: A	Luck						12 hrs
resulting in death)			Due to (or es	a consequence	ce of):	11.17				1	
Sequentially list co if any, leading to in cause. Enter Unde		h re-	n - i -							- 1	Edous
Sequentially list co	onditions,		Dua to (or as	e consequenc	e of):		7				0
cause. Enter Under Cause (Disease or	ury, leading to immediate									-	6 hrc
Cause (Disease or that initiated events resulting in death)	S	c. De	Dua to (or as	a consequanc		Sage St.	Agend .	7			
		d									
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Part II. Other signif	~		out not rasultin	g in the undark	ying cause g	iven in Part I.		23b. Did		ontribute to	
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Cun	~		out not rasultin	g in the undarh	ying cause g	iven in Part I.		1 🗆	Yes 2810	3 Pro	bably 4 Unkn
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Simple to send son the

1 Yes 2 No Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

N/A

	Plea		Print in Blac of Maryland / I	Depart	ment	of H		and N	Mental Hy		39	7027
1. Decedent's Ne	me (First, Midd		lenry, Jr.						2. Dete of De Month May		Yeer	3. Time of Death 10:42 p.m.
Contract Contract		n, give street and no dventist					4b. City, To		ocation of Deat		County of Dear	
5. Social Security N/A	Number	6. Sex 1 ★ 2 □ F	7. Age (In yrs. last bi		f Under lonths	1 Year Deys	If Under Houra	24 Hrs. Min. 05	8. Dete of Bir (Month, De May 11	_	9. Bir	thpiace (State or Foreign ountry) ryland
Usual Residence	of Decedent											4
10a. Stete MD	10b. County Mon	tgomery	10c. City, Tow Tako	oma Pa								10d. Inside City Limits 1 1 Yes 2 □ No
10e. Street and N	lumber				10f. Zip	Code				10g. Citi	zen of What Co	ountry?
7220 -	16th A	venue				209	12			U	SA	
11. Maritel Status		12. Was Dec Armed F	cedent Ever in U,S. orces?	13. Was	Decedes, speci	ent of H	lispanic Or an, Mexica	rlgin? (Sp n, Puerto	ecify Yes or No Rican, etc.)	)-	14. Raca - Ame Black, Whit	

Specify: Black

16b. Kind of Business/Industry

N/A

20912

MD

18. Mother's Name (First, Middle, Maiden Surname)

**Funeral** Director Director Funeral by

Completed

Be Tol

**Physician** 

/Medical

Examiner

1 Never Married 2 Married

3 ☐ Widowed 4 ☐ Divorced

Elementery/Secondary (0-12) N/A

17. Father's Name (First, Middle, Last)

15. Decedent's Education (Specify only highest grade completed)

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

Collega (1-4or 5+) N/A

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-4 show any Injury or other traumatic event, it a Medical Examination must be notified at page.

Baltimore, Maryland 21215-0020

**Physician** /Medical **Examiner** 

Medical Certification: To Be Completed by Physician/Medical Examiner attending physician and I for use as the bunal-transit signed by the atter completely filled in by the funeral director, page 2 should To the Hospital or Atlanding Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I

Division of Vital Records, P.O. Box 68760,

Michael Anthony	Henry		Elai	ne Reid	1	
19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailing Add	ress (Street and Number or Fington Adventi	Rural Route Num	ber, City or Town,	State, Zip Code)
Suseela Drumhell	er, Birth Reg.	Washi 7600	ngton Adventi: Carroll Ave.,	st Hospi Takoma	tal Park, MI	20912
20a. Method of Disposition		Placa of Disposition cometery, crematory	(Name of or other place)	Data	20c. Location -	City or Town, State
1 ☐ Buriel 2 【ACremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		tist Hospital	1999	Takoma	Park, MD
21. Signeture of Funeral Service License	Nikki Allen,	VP 22. Nam	e and Address of Facility ington Advent	ist Host	nital	
Mikhell	"ele		Carroll Aven	_		MD 20912
23a. Part . Enter the disease, or complished, or heart failure. List only or	cations that caused the dea ne cause on each line.	th. Do not enter the	mode of dying, such es cardia	ac or respiratory	arrest,	Approximete Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	Cardiac	Arrest				
resolute in death)	Due to (	or as a consequence	of):			
	Severe I	rematurit	y @ 21 WKS			
Sequentielly list conditions,	Due to (	or as a consequence	of):			
Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Preterm	Delivery				
that initiated events resulting in death) Last		or es a consequence	of):			1
Todating in county cast						
:						1
Part II. Other significant conditions con	tributing to death but not re	sulting in the underly	ing cause given in Part I.	23b. Die	d tobacco use co	ntributs to the cause of death?
		,		10	Yes 2X No	3 Probably 4 Unknown
					2,100	
				24a. Wa	s an autopsy formed?	24b. Wera autopsy findings avelleble prior to completion of cause of death?
				1	Yes 2 No	1 ☐ Yes 2 ☐ No
25. Was case referred to medical			26 Piace of De	eath (Check only	onel	
examiner? 1 ☐ Yes 2 ☑ No	lospital:	FR/Outpatient 3F	DOA Other: 4 Nursing			er (Snecify)
27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of thjury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 Yes 2 No		how Injury occur	
3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	nome, farm, street, fa	ctory, office	28f. Location City or T	(Street and Numb own, State)	per or Rural Route Number,
29a. Certifier 1 Certifying Physic (Check only one) 2 Medicat Examin	niclan: To the best of my known or the basis of examinating and manner stated.	owledge, death occu ation and/or Investiga	rred at the time, date and place ation, in my opinion, death occ	ce, and due to the curred at the time	e cause(s) and ma e, date and placa,	anner as stated. and due to the cause(s)
29b. Signeture and title of certifier	9		29c. License number		29d. Date signe	d (Month, Day, Year)
I due So		_	D52750		05/	21/99

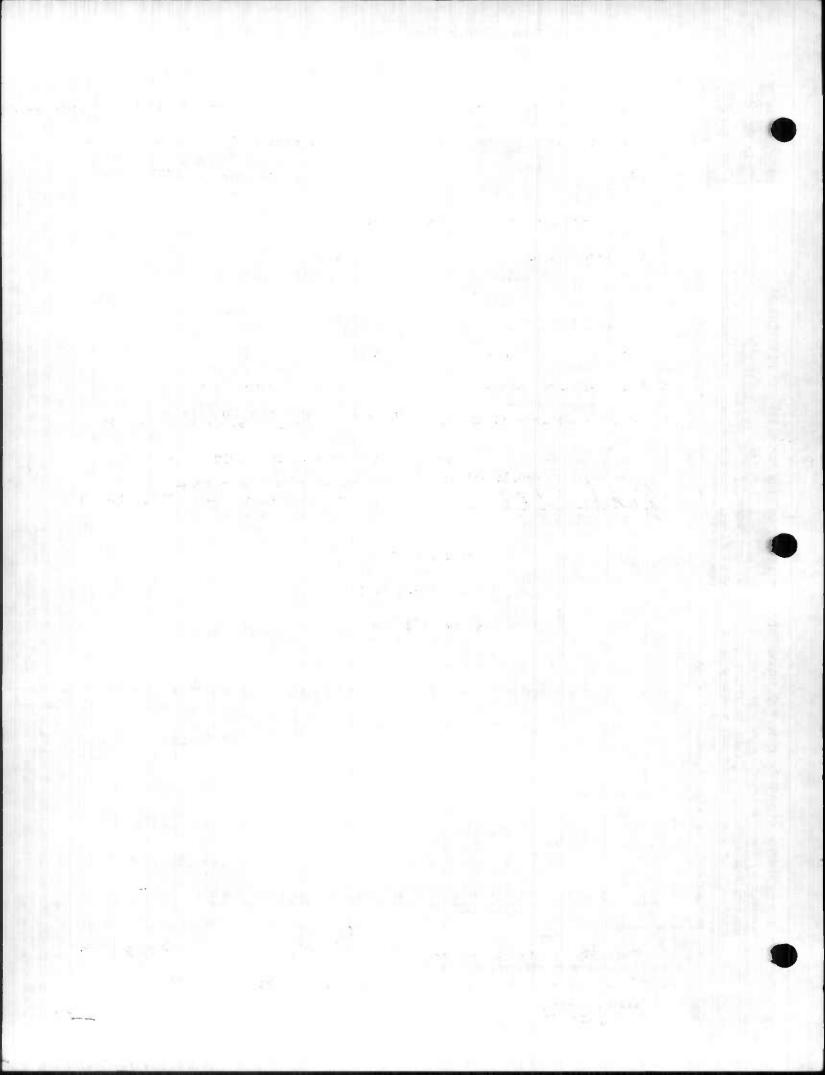
State Registrar

31. Date filed (Month, Day, Year) MAY 2 7 1999

Lincoln Ferguson, M.D., 7600 Carroll Ave., Takoma Park, 32. Registrar's Signature

9 30. Name and address of person who completed Juse of death (Item 23a) (Type, Print)

B. Spark



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

ITEM	1.5	Decedent'a Nam	e (First, Middl	le. Last1								2. Dete of D	Reg. No			3. Time	of Death
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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month May 25, LEONARD JOHN KOGUT, SR. 6:18 p.m. 4e. Fecility Name (If not Institution, giva street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 313 Linwood Avenue Bel Air Harford Houra Min. April 28, 1920 5. Social Security Number If Under 1 Year 7. Age (In vrs. lest birthday) 9. Birthpleca (Steta or Foreign 1X M 2□ F 79 Months Days Pennsylvania 217-18-3266 Usuel Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 □ No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 313 Linwood Avenue 21014 U.S.A. 12. Was Decedent Ever In U.S. Amped Forcas? 1 ½ Yes 2 □ No If Yes, Give Yeer or Detes: 1944-46 11 Marital Status Was Dacedent of Hispanic Orlgin? (Specify Yea or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indien. Bieck, White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorcad White 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 2 years Chief of Quality Control Martin Marietta 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Thomas Kogut Mary C. O'Kosh 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Catherine A. Kogut (Wife) 313 Linwood Avenue, Bel Air. MD. 21014 20b. Plece of Disposition (Nema of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Burlel 2 Cramation 3 Removel from Stata Bel Air Memorial Gardens 5/29/99 5 Other (Specify) Bel Air, Maryland 21. Signatury Funarel Servica Licenti 22. Nama and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD. 21 23e. Pert1. Effer the disease, or comb sations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, App. 21014 Approximete Intervel Between Onset and Daath Ischemic Cardioanyopathy Due to (or es e consequence of): warany artery disease Immediete Ceuse (Finel disease or condition resulting in deeth) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of) Due to (or es e consequenca of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Onknown ongestive ai Cure 24b. Were eutopsy findings eveileble prior to 24e. Wes an eutopay completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes all No 25. Was case referred to medical

sician end buriai-transit P.O. Box 68760 iding physician es the signed by Records, Division of Vital this

After t

death.

Hospital or Attending 24 hours effect death
 Funeral Director: A

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Examiner Physician/Medical Completed Be 2 Certification: filled in by

**Physician** 

/Medicai

Examiner

Director

à

Completed

Be

**Funeral** 

Director

important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any Injury or other traumatic event, I've Magical Examinar must be notified as

permit. Peges 1 end 2 should be filed Department of Health end Mentel Hygic Important: If item 27 is marked other

**Physician** 

/Medical **Examiner** 

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with the Marylend

26. Piece of Deeth (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Aesidenca 6 ☐ Other (Specify) 1 ☐ Yea 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how Injury occurred

1 Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 - Homlcide

1 Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(a) and menner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete and pleca, end due to the ceuse(s) end menner stated. 29e, Certifier (Check only one)

29b. Signatura and title of cartifiar 29d. Date algned (Month, Dey, Yeer) 29c. License number

Attending 16444 May 26th 1999

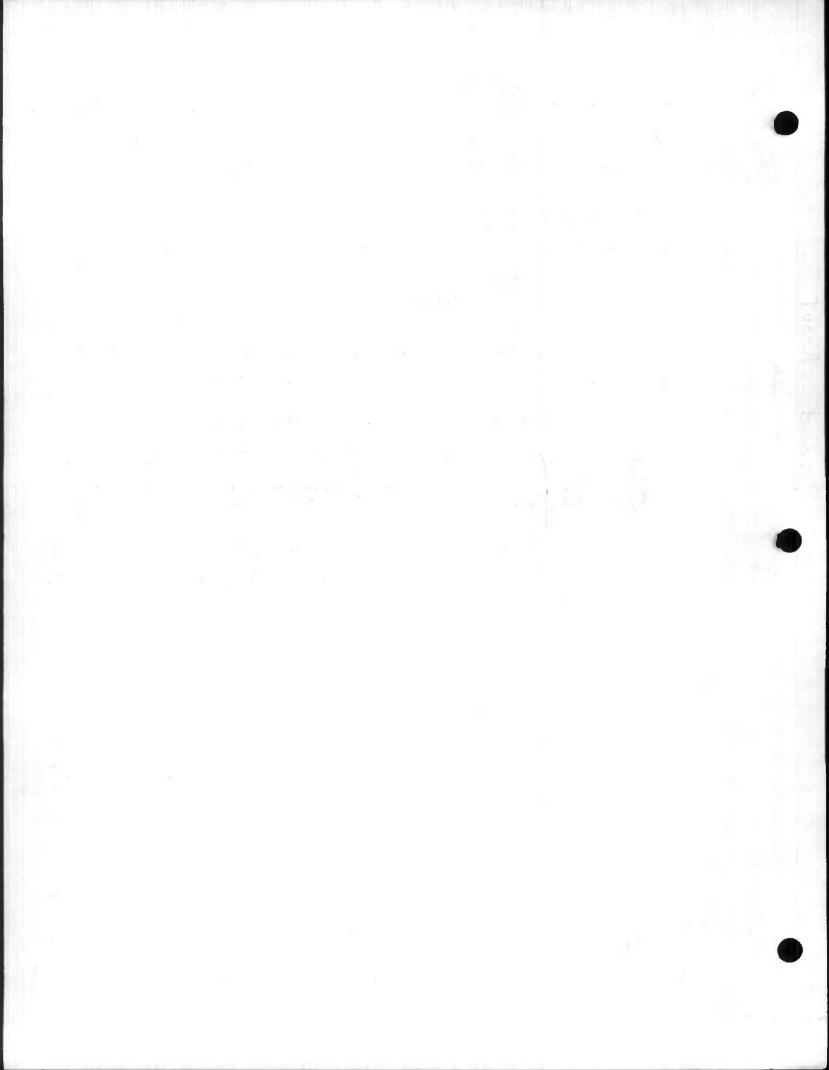
30. Name end address of person who completed cause of deeth (Item 23a) (Type, Brint) VIJAY. S. NAIR M.D. 2112 BELOUR ROAD. FALLSTON. MD21047 31. Dete filed (Month, Dey, Year)

State Registrar

edicai

MAY 27





Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ITEMS: #19B PER F.H. G7771 5-27,1999 WR. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Knox 10:02 MAY 21 99 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Horst of BON SECOUM maylen 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) / / **Funeral** 1MM 2 F 213-18-6077 Va Director Usual Residence of Decedent death with the Menylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits th end Mental Hygiene. 7 Is marked other than "natural", or frems 23s or 28s-f show traumstic avent, the Michigal Examiner must be noutred as 1 Yes 2 No Md Baltimore Director NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 U.S.A Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11. Marital Status Black, White, etc. Peges t end 2 should be filed within 72 hours efternent of Health end Mental Hygiene. 1 Never Married 2 Married 1 Yes 2 No Specify: Black ρ 3 Widowed 4 Divorced Yeer or Detes: Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
lite. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) STA-ILA College (1-4or 5+) Longshoreman grade WA 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Meiden Sumeme) Be oumes Cuans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2/2/6 permit. Peges t end 2 sh Department of Health end Important: If itam 27 Ia m any Injury or other traum once. Dalto, rep de lla CLAYMONT AVE. Snox-20b. Place of Disposition (Neme of 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremetion 3 Removal from State Kandallstown Hed emonal 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Supplie Licensee Suenue red Part 1. Enter the disease, or complications that a dised the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death mode of dying, such as cardiac or respiratory errest, **Physician** Coronary /Medical Immediate Ceuse (Final Hours disease or condition resulting in deeth) Examiner Physician/Medical Examiner attending physician end for use es the burief-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest 4 caps Lachemu Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detached 1 Yss 2 No 3 Probably 4 Whiknown à 24b. Were autopsy tindings eveileble prior to completion of cause of deeth? Completed 24a. Was an autopsy After this certificate has funeral director, page 2 1 Yes 2 No 1 Yes 2 DAG or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA rector: After this by the funeral of 27. Menner of Death Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? 5 Pending investigation 1 Maturel death. 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) efter within 24 hours efter To the Funeral Direc completely filled in by 4 Homicide Hospital 1 Tertifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner es stated.

2 Madical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

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MAY 27 1999

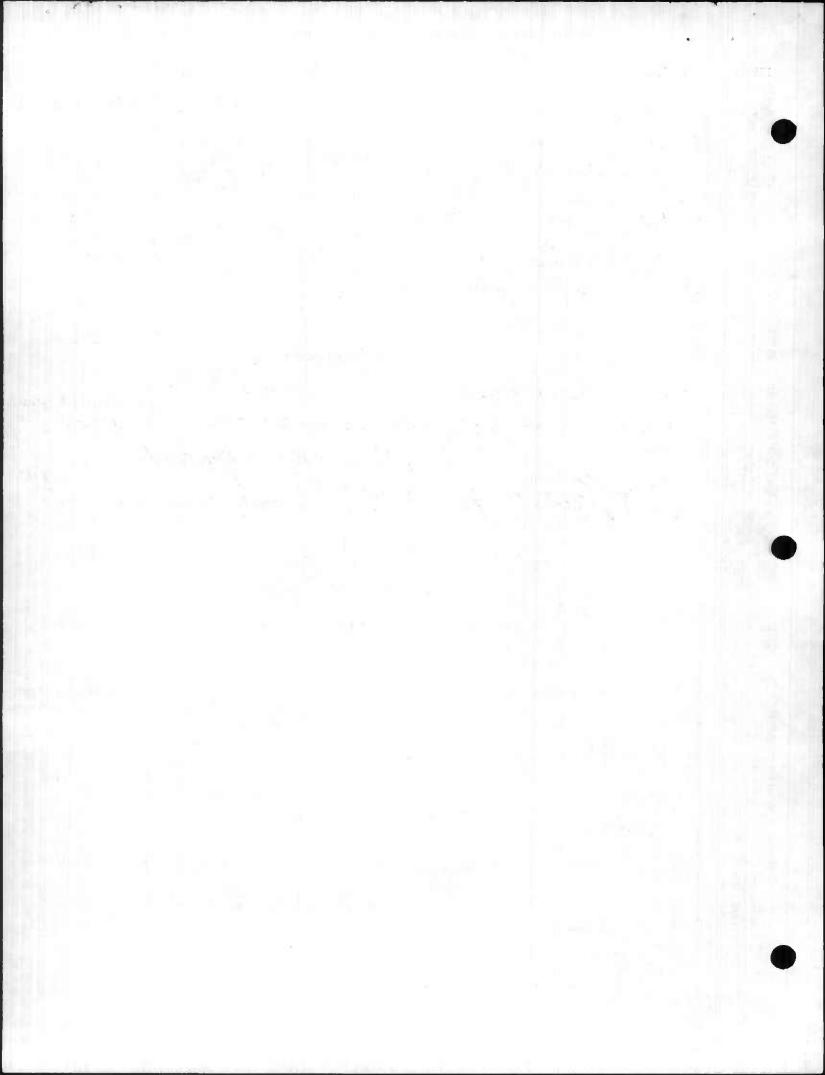
olenso mahunda.

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

32. Registrar's Signature

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Physician	ART I, 27 PER MEO G77  1. Decedent's Name (First, Middla,  John M. Kaspr:	Last)	ır.	06	ertificate	, OI L	Joan		2. Data of Dea Month	Day	Year	3. Tima of Death 0839 AM		
/Medical Examiner	4a Facility Name (If not institution, g BAYVIEW MEDICA:	giva street and numi	ber)			4	b. City, Too BALT		cation of Death	25, 19 4c. Count N/A	y of Death	0037 741		
uneral rector	5. Social Security Number  214-50-4101  Usual Rasidence of Decedent	Sex 7 X M 2 □ F	4. Age (In yrs. 4.8	last birthday Yrs.	Months	1 Yaar Days	If Under a	24 Hrs. Min.	8. Data of Birth (Month, Day 01-25-	51	9. Birthpl Count	ace (Stata or Foreig		
ari show illad at otor	MD 10b. County N/A			y. Town or L ltimo				П			10	od. Inside City Limit		
23a or 28a-f show wat be notified at rai Director	10e. Street and Number 6721 Roberts A		10f. Zip	Code 222			1	10g. Citizen of What Country? USA						
Examiner in by Fune	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Ford 1 Yas 2 If Yas, Giva	12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Giva Year or Dates:			ent of Hi ify Cuba	ispanic Oriç n, Mexican Specify:	jin? (Spe , Puerto I	ocify Yas or No- Rican, etc.)	Bla	ce Amarica ick, White, a White	The state of the s		
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ry or oth	20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		lata	ematery, cre	osition (Nem emetory or ot anisla	her plec	e)	5_	Dete 28-99	20c. Location				
no properties	diseasa or condition rasulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	а. <u>HYPERTE</u> b	Due to (o	r as a conse	equence of):				or series					
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hould be d						1			24a. Was a perfor	n autopsy	24b. Wa	are autopsy lindings pilable prior to inpletion of ceuse death?		
	25. Was casa refarred to medical			Ш,			26 Plane	of Death	X	as 2 No	115	1 _		
I director										Home 5 Rasidence 8 Othar (Specify)				
OD:	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28. Data of Injury (Month, Day Year) 28. Injury Work? 1 Natural 1 Year 2 (Month, Day Year)							2	28d. Describe how injury occurred					
completely filled in by the funeral	3 Suicide 6 Could not detarmine	28a. Place o	f Injury - At ho , etc. <i>(Specif</i> )	oma, farm, s	treet, factory,	office		2	28f. Location (Street and Number or Rural Routa Number, City or Town, Stete)					
pletely fill	29a. Certifier 1 Certifying F (Check only one)	Physician: To the be aminer: On the bas and manna	is of axaminat	wledge, dea lion and/or in	vastigation,	in my op	oinion, deet	d place, a h occurre	ed at the time, d	late end place	, and due to	ated. the cause(s)		
Med Med	29b. Signatura and titla of certifier						number			9d. Date sign				

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State of Maryland / Department of Health and Mental Hygiene ()

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death 20<sup>Dey</sup> Month Physician Ruth Helen Klimas 1999 6:00PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare Baltimore N/A If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 20 F 13, 217-26-4187 85 DÉC. Director 1913 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-1 show Y Yes 2 No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 1122 Sargeant St. 21223 USA "natural", or flams 23s 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Status Bleck, White, etc. filed within 72 hours after Hygiene. Ther than "natural", or its 1 ☐ Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: white þ 3 DWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Papes 1 and 2 should be filled w Department of Health and Mental Hygien Importants If Nem 27 is marked other thy any Injury or other traumetra Homemaker Own Home 6 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Be Maynard Sherman Rose (Unobtainable) 19e. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1122 Sargeant St., Balto., Md. Kenneth M. Klimas - son 20s. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete Dete 5/22/99 1 Burial 2 Cremetion 3 Removel from State Elkridge, Md. 4 ☐ Donetion 5 ☐ Other (Specify) Meadowridge Memorial Pk. 22. Name end Address of Facility
Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 21. Signeture of Funeral Service Licensee 7250 Washington Blvd., Elkridge, Md.

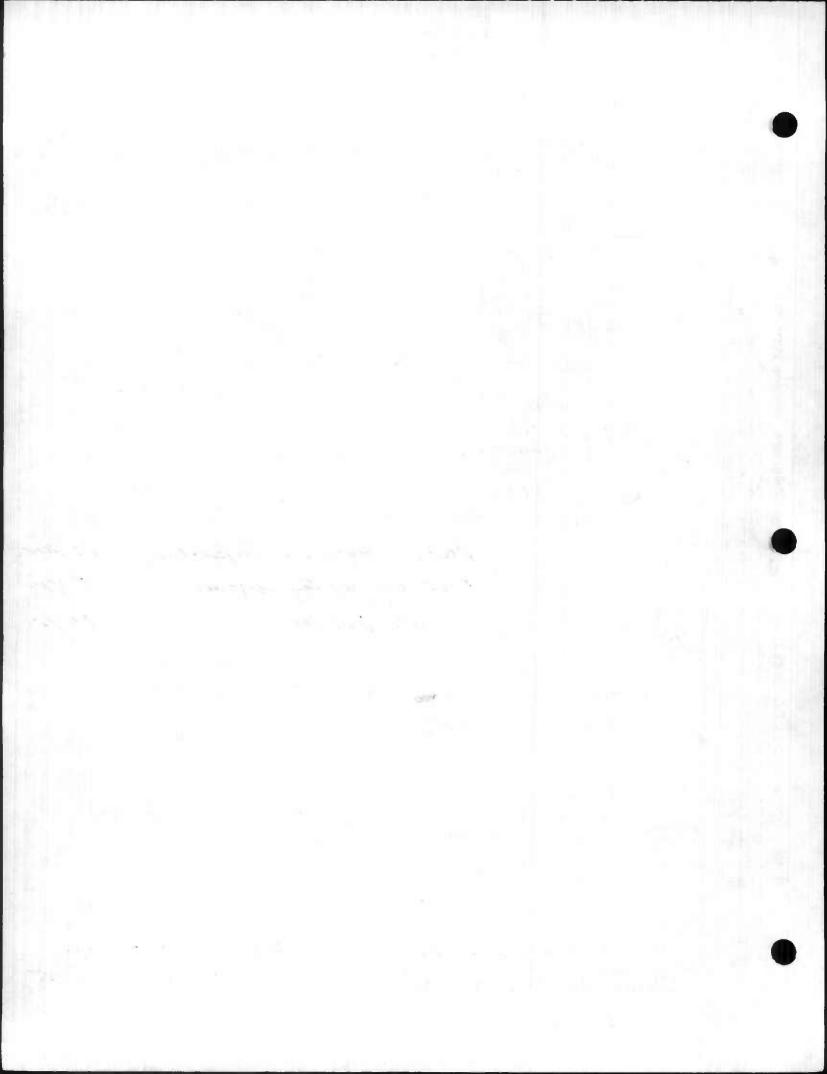
23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset end Deeth **Physician** My olandial Proposition Immediata Cause (Finat disease or condition resulting in death) /Medical 10 Meno Examiner Examiner physician and s the burial-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) 788 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown þ 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? Completed 1 ☐ Yes 2 -NO 1 Yes 2 No Division of Vitai e Hospital or Atlanding Physician: 124 hours after death. e Funeral Diractor: After this certifical letaly filled in by the funeral director, i Be 25. Was case referred to medicat axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? 1 Netural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier edicai To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) nenezes D07309 uns. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Silvino MUNESES MD 3721 POTCE STREET BALTIMORE, MD 21225 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State

**DHMH 16 Rev 6/95** 

Registrar

MAY 27 1999



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State of Maryland / Department of Health and Mental Hygiene

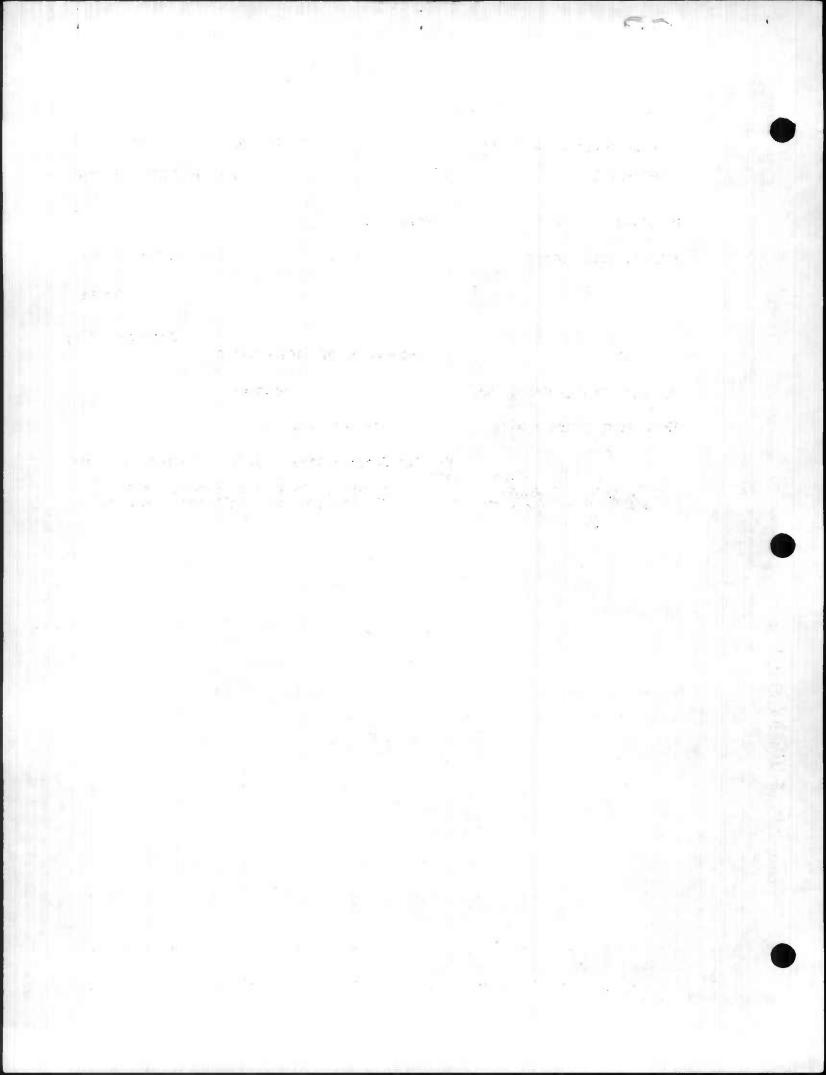
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2 Data of Death 3. Time of Death Month **Physician** 1:33 A TEREMIAH D. KREBS MAY 6 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number, 4c. County of Death Examiner Baltimore Union Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Birthplaca (Stete or Foreign
Country) **Funeral** 1**X**]M 2□F Months Days Hours Yrs. 69 April 19,1930 Director 215-28-0163 Maryland Usual Residence of Deceden with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Medical Examinet must be not the dis-1X Yes 2 No Directo Maryland N/A Baltimore 10f. Zip Coda 10g. Citizan of What Country? 10e. Street and Number 1327 W. 37th Street 21211 United States death Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ሺ No If Yes, Give Yaar or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health end Mental Hygiene. Important: If item 27 is marked other then "natural", or iter 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 K No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede complated) 16b. Kind of Business/Industry Baltimore City Elementary/Secondary (0-12) Coilege (1-4or 5+) 12 Supervisor of Construction 18. Mothar's Name (First, Middle, Meiden Sumame) 17. Fathar's Nama (First, Middle, Last) Unknown Jeremiah Daniel Krebs, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Nancy Krebs / Wife Same as item 10e. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stata 1 Buriai 2 Cremation 3 Ramovai from Stata Injury or 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 5/27/99 Towson, Maryland 21. Signature of Funeral Service Licensee /Timothy Harman 22. Name and Address of Facility Leonard J. Ruck, Inc. Funeral Home 5305 Harford Road Baltimore, MD 21214 23a. Part 1. Enter the diffuse or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** /Medical immediate Cause (Final 10 days disaasa or condition resulting in death) Examiner Que to (or as a consequence of) Physician/Medical Examiner IVER 6 da physician end s the burial-transit The law requires that the death certificate be executed Sequantially list conditions, if any, leading to immadiate cause. Enter Underlying Causa (Diseasa or Injury that initiated avants rasulting in death) Last Due to (or as a consequence ot) Division of Vital Recolds, P.O. Box 68760, 23 day MITRAL REGURGITATION VALVE Due to (or as a consequenca of): 2.3 days ENDOCARDIT! signed by the all d be deteched for Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part i. 23b. Did tobacco use contributa to the ceuse of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Wera autopsy findings evailable prior to Completed 24a. Was an autopsy performed? completion of cause of death? frector, page 2 s 1 Yes 2 KNo 208.No chronic rena or Attending Physician: after death. 25. Was case referred to medical examiner? Be 28. Piaca of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2,⊠No 1 inpatient 2 ER/Outpatient 3 DOA After this 28a. Data of Injury (Month, Dey Year) 27. Mannar of Death 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: 28b. Time of 1 Natural 5 Pending 1 ☐ Yas 2 ☐ No Investigation 2 Accident 6 Could not be datermined 3 ☐ Suicide 28f. Location (Straet and Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At homa, farm, straat, factory, offica building, etc. (Specify) 4 Homlcide To the Hospital of the Funeral D completely filled 1 Certifying Physician: To tha best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and manner as stated.

1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner statad. edical 29a. Cartifier 29b. Signature and titla of certified 29c. Licanse number 29d. Date signed (Month, Dey, Year) AT2438946-N4 MD MAY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 E. UNIVERSITY PARKWAY, BALTIMORE MD 21218 NIGEL MD 31. Date filed (Month, Day, Year) 32. Registrar's signatura State

**DHMH 16 Rev 6/95** 

Registrar

MAY 27



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dycodunt's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8:37 22 TOOL . To the control of the street and number) 4b. City Town, or Location of Du 4c. County of D 7000 mo If Under 5. Social Security Number 7. Age (In yrs. last birthday) e (State or Foreign Months 1 M 2 F 213-30-311 Yrs. Usual Residence of Decedent 10c. City/Town or Location 10d. Inside City Limits 1 Pres 2□No TIMORE 10e. Street and Number 10t. Zip Code 10g. Citizen of What Country? asc Origin? (Specify Yes or No-Mexican, Puerto Rican, etc.) Was Decedent of Hispe If Yes, specify Cyban, N 11 Marital Status Was Decedent Ex 1 Never Married 1 Yes 2 Very Yes, Give Year or Dates: 2 0 No 3 ☐ Widowed 4 € Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
| Iffs. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Nama (First, Middle, Last) OODROW DERTHA Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Roote Number 0 20a. Meltiod of Disposition 1 M Burial 2 ☐ Crematio 20b. Place of Disposition (Na 4 Donation 5 Other (Specify) 21. Signature of Suneral Service Lipens on 0 mondson Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 10tric Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 4 Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 250 No 1 ☐ Yes 2 ☐ No

Physician Examiner Box 68760,

P.O.

Records.

Vital

to

Division Attending

To the

The law regu

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

28a-f show

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is marked

Important: If Item 27 I any Injury or other In-

Saltimore, Maryland 21215-0020

Pages 1 and 2 should be nent of Health and Mental

Director

Funeral

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Completed

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To

Physician/Medical à Be Completed Certification: To

Medical

State

差 Attar Hospital or An
 Court after death.
 A Director A
 Director A within 24 hours a To the Funeral C

29s. Certifier 29b. Signatur

1 Yes

27. Manner of Death 1 (Shatural

2 Accident 3 Suicide

4 Homicide

languagi (am 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manifer stated. 29d. Date signed (Month, Day, Year)

Other: 4 Nursing Home 5 Residence 6 Sother (Specify)

28d. Describe how injury occurred

26. Place of Death (Check only one)

ath (Item 23a) (Type, 30. Nam PIH

31. Date filed (Month, Day, Year)

25. Was case reletred to medical examiner?

holino

5 Pending investigation

6 Could not be

1 Inpatient

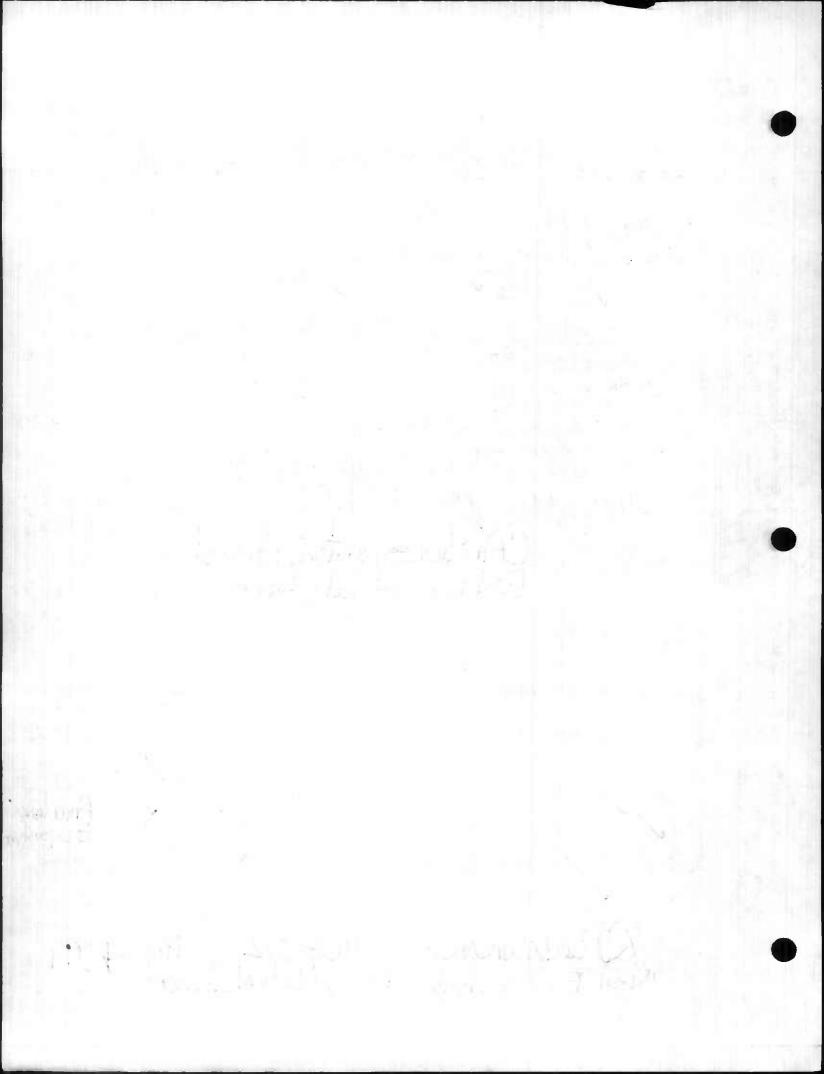
2 EP/Outpatient 3 DOA

28c. Injury at Work?

26b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar **DHMH 16 Rev 6/95** 



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Deeth 3. Time of Death **Physician** MAY 19, 1999 Yaeı KARAFIN 10:20 PM /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** JEWISH CONVALESCENT & NURSING HOME BALTIMORE BALTIMORE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAY 26,1917 5. Social Security Number If Under 1 Yaar 7. Aga (In yrs. lest birthday) Birthplaca (State or Foreign Country) **Funeral** 1 X M 2 □ F Days Director 182-05-1911 81 PA Usual Residence of Deceden the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itams 23s or 28a-f show traumstic event, the Medical Examinar must be notified at UNKNOWN Yes 2 No Director CA NORTH HOLLYWOOD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13000 VICTORY BOULEVARD 91606 U.S.A. Funeral death 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ∑ No If Yes, Give Yaar or Dates: Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: þ 3 ☐ Widowed 4 ₺ Divorced WHITE Completed 15. Decedant's Education 16a. Dacedant's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working lifa. DO NOT use retired) (Specify only highast grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Manlel Hygiene. Important: if item 27 is marked other than any injury or other traument. Elamantary/Secondary (0-12) College (1-4or 5+) PROPRIETOR BAR SUPPLIES 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maidan Surname) Be KARAFIN SAUL **ESTHER** KERAFIEL 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Route Number, City or Town, Stete, Zip Coda) BRIAN KARAFIN / SON 12121 FAULKNER DRIVE - OWINGS MILLS, MD 21117 20b. Place of Disposition (Neme of cemetary, cremetary or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 🛣 Ramoval from State 5/20/99 EDEN MEMORIAL PARK SAN FERNANDO, CA 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 art1. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cerdiac or respiratory arrest, shock, or heert failura. List only one ceusa on each line. Approximate Interval Between Onset and Death **Physician** Cerebroussoula Pocadant /Medical Immediata Cause (Final disaasa or condition rasulting in death) Examiner Examiner rne un oni a bunal-transit end Sequentially list conditions, if eny, laading to immediata ceusa. Enter Underlying Cause (Disaasa or Injury that Initiated events rasulting in death) Last Dua to (or as a consequence of) P.O. Box 68760, ettending physician for use es the buna 99 Physician/Medicai Due to (or es a consequance of): Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings available prior to completion of ceuse of death? 24a. Was en eutopsy performad? Completed hes page 2 certificate 1 Tyes 2 JUG 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifica 25. Was casa referred to madical Be 26. Piece of Death (Check only one) Hospital: 70 Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Deta of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28c. Injury et Work? 28d. Dascribe how injury occurred Certification: 1 Natural 5 Panding Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be detarmined 3 Suicide 28e. Place of Injury - At home, tarm, street, factory, office building, atc. (Specify) 281. Location (Street end Number or Rural Routa Number, City or Town, Stete) 4 Homicida Medical 1 Certifying Physician: To the best of my knowledge, daath occurred at tha tima, date and place, end dua to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Cartifies completely 29b. Signeture and title of certifier 29c. Licansa number 29d. Date signed (Month, Dey, Year) Know completed cause of death (Item 23a) (Type, Print) PIKesulle, Man (00 2. Registrar's Signeture State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dele of Death 3. Time of Deeth LUCY Month Year **Physician** ZUGENE RONALD 12=32+1 MAY 1999 19 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ALLSTON GEN. HOSPITAL FALLSTON F

ther 6. Sex 7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. (Month, Day, Year) FONO 5. Social Security Number Birthplece (State or Foreign Country) 12M 2□ F 53 214-50-421 Usual Residence of Decedent Yrs Director MD 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Marylei ma 1 Nes 2 No BAHTIMORE Director 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? 7 is marked other than "natural", or items 23a or traumetic event, the Medical Examiner must be a 21240 804 Kingston W15,A CT Pages 1 and 2 should be filed within 72 hours efter death nent of Health end Mental Hygiene.
nt: If item 27 is marked other than "natural", or items 23. Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1□ Yes 2□No Baltimore, Maryland 21215-0020 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-for 5+) Elamentary/Secondery (0-12) Food Service Director 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumerna) Be GOVEVIENCE John Lucy 19b. Malling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 1240 19a. Informant's Name/Relationship (Typa, Print) 20b. Plece of Disposition (Name of cemetery, cremetory or other piece) WHR Ford County

20c. Location - City or Town, State enises Lucy 20a. Method of Disposition uniel 2 Cremation 3 Ramoval from Stata
4 Donallon 5 Other (Specify) 6 Department of Important: If any Injury or 21. Signature of Fune al Service Licensee 23a. Part1 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shoc or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediata Cause (Final DISEASE METASTATIC disease or condition resulting in death) Examiner Dua to (or as a consequance of): Examiner CARCINOMA Sequantially list conditions, if eny, leeding to immadiate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last physician and the buriel-tran Dua to (or es a consaguance of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown DIABETED MELLITUS À 24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? Completed 24a. Was en eutopsy performed? HIPERTENSION COID 1□ Yes 2 No 1 ☐ Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours effer death.

To the Funaral Director: Affer this cariffici completely filled in by the funeral director, 25. Wes case referred to medical axaminer? Be 26. Placa of Death (Check only ona) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 No 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Dey Year) 28c. Injury at Work? 27. Mannar of Death 28d. Dascribe how Injury occurred 28b. Time of 1 Natural 2 Accidant 5 Panding investigation 1 ☐ Yas 2 ☐ No 3 ☐ Sulcide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, tarm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledga, daath occurred at the time, dete end place, end due to the ceuse(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, dete and place, end due to the ceusa(s) and menner stated. Medical 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME 1999 30, Nama and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 218 FULFORD BELAN MD 21014

32. Registrarie Signeture

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Tima of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Death 256 pm Month **Physician** 22 AUCIA LANGIEY /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltmore City Hospital maryland General If Undar 1 Year If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 12-15-60 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2ØF Days 217- Icle-8287 Usual Rasidanca of Decedant MD Director the Marylend 10e Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 Vas 2 □ No BALTIMORE NIA Directo 10e. Street and Number 10f. Zlp Coda 10g. Citizan of What Country? 72 hours after death with 7 is marked other than "natural", or items 23s or traumatic event, the Medical Example must be 1504 MOUNT 2121 MOORE USA Funeral 12. Was Decedant Ever in U,S. Armed Forcas? 1 Yas 2 No If Yas, Giva Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indian Black, Whita, etc. 1 Naver Marriad 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: by BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 18a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry nit. Pages 1 and 2 should be filed within seriment of Health and Mental Hygiene, ortant: If itam 27 is marked other than "I Injury or other traumatic event, its Mac Elemantary/Secondary (0-12) Collega (1-4or 5+) BALTO. CITY SCHOOLS SCHOOL ALDE GRADE YR 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumame) Be MORRIS LANGLEY RENE AWSON 19a. Informant's Name/Relationship, (Type, Print) 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) SISTER 1732 PAUL BALTO KIMBALL VERNADINE MD 20b. Placa of Disposition (Nama of camatary, crematory or other place) Data 20c. Location - City or Town, Stata 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State permit. Page Depertment of Important: If it 5-28.99 4 ☐ Donation 5 ☐ Othar (Specify) CREMATORY 21. Signature of Funeral Sarvice Licensee 22. Name and Addrass of Facility VAUGHN C. GREENE FUNERAL SER. house, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrast, lure. List only one cause on eech line. 21229 BALTO. MO. 23a. Part1. Entar the din shock, or hand failu Approximata Intervat Batween Onset and Death **Physician** /Medical Immediata Causa (Final PERFUSION ecreased diseasa or condition resulting in daath) Examiner Necrolysis Examiner Epidermal sician end bunel-transit certificate be executed Sequantially list conditions, if any, laeding to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting In death) Last Stage Acquired Immunodeficiency Syndrome physician the bune P.O. Box 68760, Physician/Medical as 950 signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 3 Probably 4 D Onknown 1 Yes 2 No Division of Vital Records. à 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy performed? peed complation of causa of daath? page 2 hes 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificate Hospital or Attending Physician: funeral director, 25. Was case rafarrad to medical axaminar? Be 28. Place of Deeth (Check only one) Hospital: Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Yas 2 No 1 Inpatiant Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28d. Describe how Injury occurred 28a. Dete of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? After Naturel 5 Panding efter death. Director: Aft 1 ☐ Yas 2 ☐ No Investigation 2 Accidant 6 Could not be determined 3 Suicide 28a. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicida 24 hours e edicai 29a. Certifiar 1 Cartifying Physician: To tha best of my knowledge, daeth occurred at the time, dete and plece, and due to the cause(s) and menner as stated. completely (Check only one) 2 Medical Examinar: On the besis of examinetion end/or invastigation, in my opinion, death occurred at the time, date end place, and due to the causa(s) and manner stated. To the I 29b. Signetura and titla of cartifiar 29c. Licansa number 29d. Data signad (Month, Day. Year) MID 30. Nema and addrass of person who completed causa of daath (Itam 23a) (Type, Print)

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Registrar

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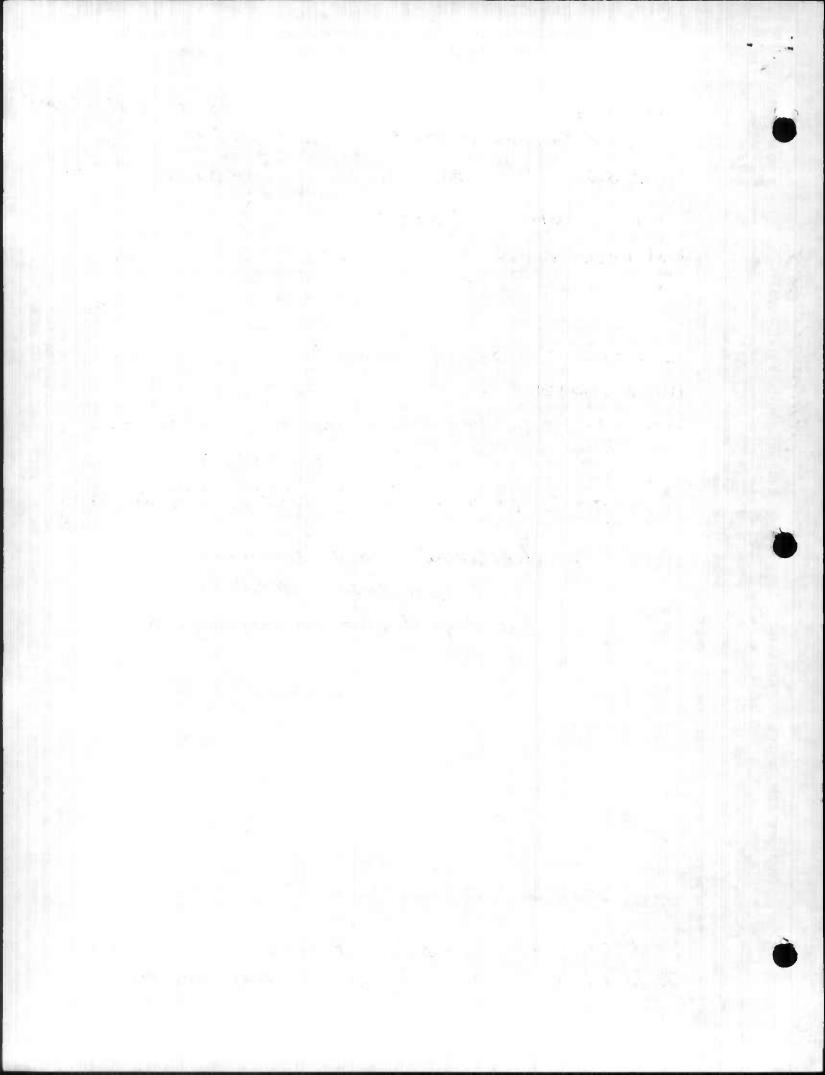
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31. Data filed (Month, Day, Year) MAY 2. 7 1999

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32. Ragistrar's Signatura



State of Maryland / Department of Health and Mental Hygiene

ent of Health and Mental Hygiene

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To the Hospital or Attending in white 24 hours after death.  To the Funeral Director: After completely filled in by the funeral Medical Certification.	(Check only one) 2 Medical Example one)	miner: On the basis of and manner sta	examination and/or inted.	nvestigation, in my	y opinion, daa	ith occurre	d at the time,	data and place,	and dua t	o the cause(s)
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** LANGE BERNARD MAY 23 1999 /Medical 48 Facility Name (If not institution, give street and number) Liberty Medical Center, 4b. City, Town, or Location of Death 4c. County of Death Examiner BACTI MORE If Under 1 Year | If Under 24 Hrs. | Months | Deys | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (Stata or Foraign Country) **Funeral** Days 18 M 20 F 88 Yrs. 212-03-6815 Director 09/19/1910 Maryland Usual Residence of Decedent The Maryland 10a State 10b Counts 10c. City, Town or Location 10d. Inside City Limits show Vores 2□No Director 28a-f Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural', or ltams 23a or 302 Kingston Road 21229 USA Funeral at Hygene. d other than "natural", or Itams event, its Medical Examiner or 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married Specify: White 21215-0020 1 Yes 2₺ No Specify: à 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tifle. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Elementary/Secondary (0-12) College (1-4or 5+) 9th Telephone Worker Telecommunications altimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Pages 1 and 2 ahould be the ment of Health and Mental Health and Mental Health and the marked oth lary or other traumatic even Be UNKNOWN UNKNOWN Lange 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Dennis G. Lange/Son 302 Kingston Rd. Baltimore, Maryland 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Louden Park Cemetery 5/27/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Service Lid 22. Nama and Addrass of Facility David J. Weber Funeral Homes, P.A. 5311 Fdmondson Ave. Baltimore, MAryland 21229

23a. Part1. Enter the disease, or continuations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Intervel Between Onset and Death Physician /Medical Immediate Cause (Final DNeuminia disease or condition resulting in death) Examiner Examiner CARCINOMA DROSTAT The lew requires that the death certificets be executed physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cereprovasculces P.O. Box 68760. Physician/Medical Due to (or es a consequence of) USB 25 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown be de Records, py 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes en autopsy performed? page 2 s 1 Yes 2 No 1 Yes 20 No certificate Division of Vitai To the Hospital or Attanding Physician: within 24 hours siter deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director; p 8 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28h Time of 28c. tnjury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stele) 4 | Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, and due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. edicai 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) N. Kem im) D17031 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KWANG N. Kim. M.D. 2000 Liberty

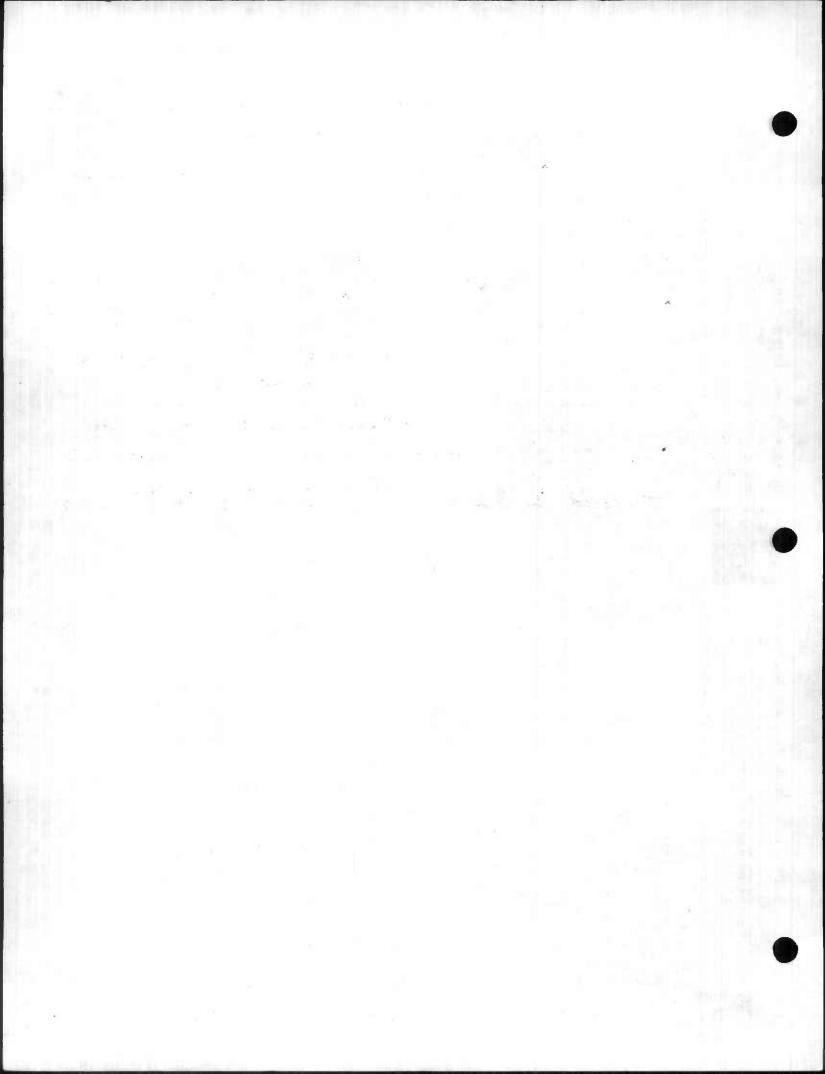
Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

MAY 27 1999 >



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** May 25, 1999 ALFRED JOSEPH MARZETTI 12:35AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, giva street and number) 4c. County of Death **Examiner** Gilchrist Center Towson Baltimore If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1₩ 2□ F Yrs. 406-32-3431 December 6, 1927 Kentucky Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 Elphin Court #201 21093 USA Funeral 12. Was Decedant Evar In U.S. Armed Forces? 1 ☐ Yas 2 Ø Yo If Yes, Give Year or Datas: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Nevar Married 2XX Married 1 ☐ Yes 2 X No Specify: by 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decadent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work dona during most of working life. DO NOT use retired) Elemenfary/Secondary (0-12) Collega (1-4or 5+) Manager Passenger Operations 18. Mother'a Name (First, Middle, Meiden Surname) 17. Father's Name (First, Middle, Last) Pia Pasquina DePiero Joseph Damiano Marzetti 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11 Flphin Court #201 Timonium, Maryland 21093. Oriana C. Marzetti Wife 20b. Placa of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XX remation 3 ☐ Removal from State Greenmount Cemetery 5/27/99 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Addrass of Facility Mitchell-Wiedefeld Funeral Home Inc. 21. Signature of Funeral Service Moerae 6500 York Road Baltimore, Maryland 21212 Part1. Enter the dishase, or the shock, or heart failure. List (high plications that be used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one days in on each line. Approximate Interval Between Onset and Death fmmediate Ceuse (Finel disaasa or condition resulting in death) end- strace ren Examiner Sequentially list condifions, if eny, leading to immediate cause. Enter Undartying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of): 23b. Dfd tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 1 Yes 2 No 3 Probably 4 D-Unknown p 24b. Were autopsy tindings available prior fo completion of cause of death? 24a. Was an autopsy Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Horne 1 Yes 2 X No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day Year) 28d. Describe how injury occurred 27. Mannar of Death 28b. Time of 28c. Injury af Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, streef, factory, offica building, etc. (Specify) 4 Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier edical

certificate be executed Box 68760, Division of Vital Records, P.O. Hospital or At 24 hours after d Funeral Direct 24 hours Funeral To the Hosp within 24 ho To the Fune completely fi

**Funeral** 

Director

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72 hours after death

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**Physician** /Medical

Examiner

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signed by the a

Baltimore, Maryland 21215-0020

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MArzett

State Registrar

31. Date filed (Month, Day, Year) MAY 27 1999

29b. Signature and title of certifier

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32. Registrar's Signature

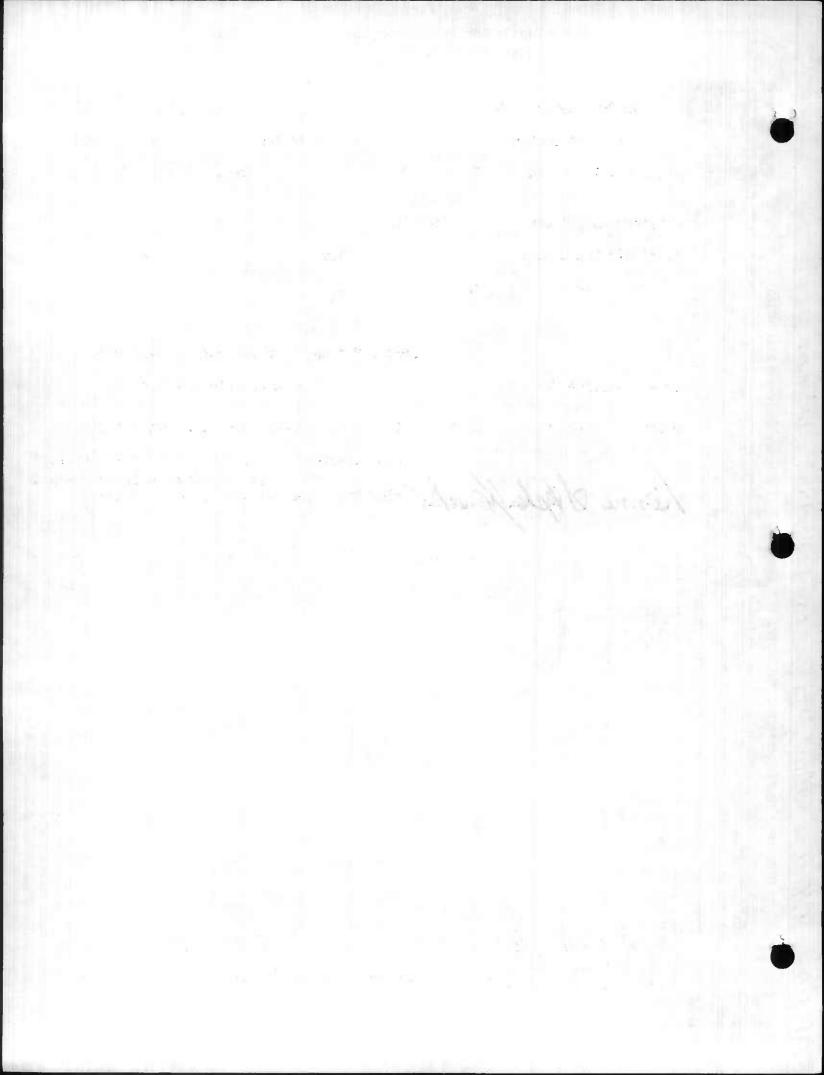
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10. A. R. Ly GBMC 6701 N. Charles St. Belto md 2120x sacker

29c. Licensa number

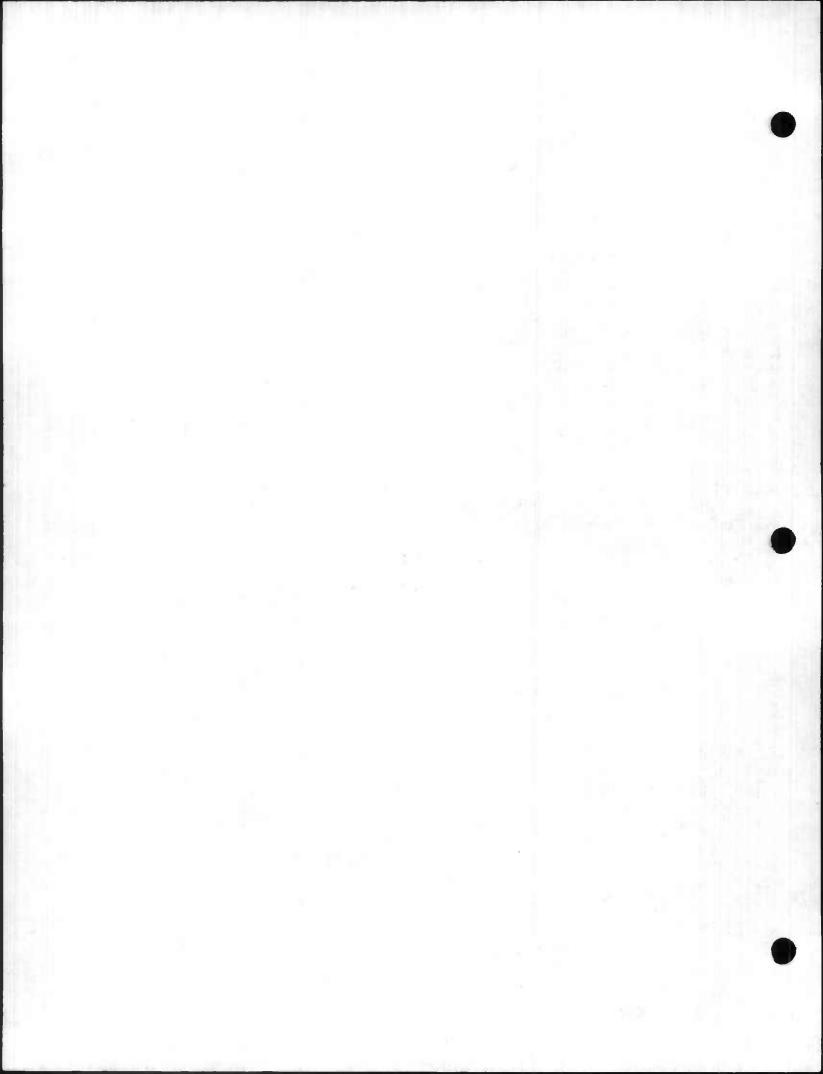
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29d. Data signed (Month, Day, Yeer)



State of Maryland / Department of Health and Mental Hygiene 9 704

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other t	20a. Method of Disposi		· · · · · ·	1	20b. Place of D	sposition (Nan	ne of		, Kel	Dale	20c. Location		
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edical		Medical Exam	niner: On the I	basis of exa	amination and/o	r Investigation,	in my	opinion, dea	th occur	ed et the time,	date and place,	and due	to the cause(s)
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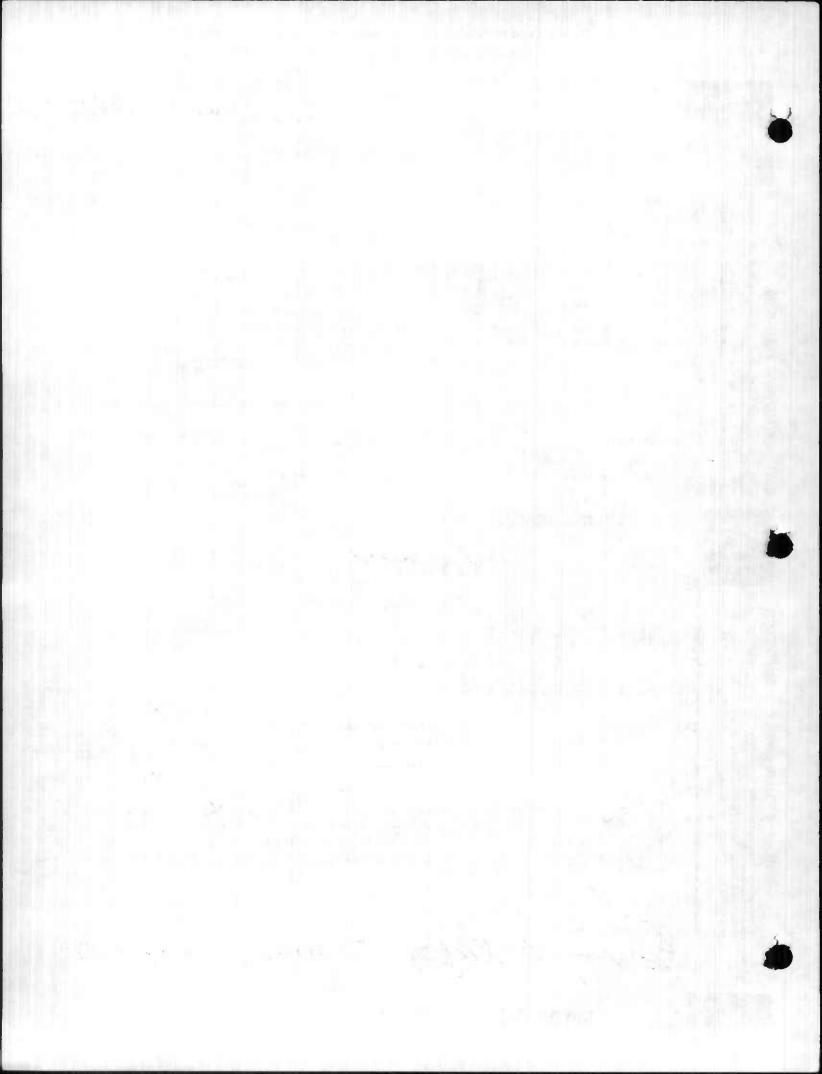
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 30 Anna NIEDZWICKI 1999 Mai /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner 905 ROSEDALE AVENUE BALTO. BALTO If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5 Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. lest birthdev) **Funeral** 1□M 2MF Months Days 215-10-9153 85 Yrs. Director Mar 30,1914 MD Usual Residence of Decedent with the Marylend 10c. City, Town or Location 10e Stete 10b. County 10d. Inside City Limits 7 is marked other than "naturel", or heme 23a or 28a-f show traumatic event, the Modical Examiner munt be notified at 1 De 2 □ No Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 905 ROSEDALE AVENUE USA 21237 deeth Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after of Deportment of Health end Mental Hygiene. Important: if item 27 is marked other than "naturel", or her eny Injury or other traumatic event. 1 Never Married 2 Married 1 Yes 2 XNo Specify: Maryland 21215-0020 Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) HOMEMAKER HOME 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) ALEXANDER MARKOWSKI UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ROBERT NIEDZWICKI 905 ROSEDALE AVENUE, BALTIMORE, MD 21237 Baltimore, 20a. Nethod of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State HOLY ROSARY CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) May121999 21. Signeture of Funeral Service Licensee 22 Name and Address of Facility KACZOROWSKI FUNERAL HOME 1201 DUNDALK AVENUE, BALTIMORE, MD 21222 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feiture. List only one ceuse on each line. Approximate Interval Between Onset end Deeth **Physician** immediete Cause (Finet disease or condition resulting in death) /Medical Cardiac MOS. Asystol Examiner Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): Box 68760, Physician/Medicai Due to (or as e consequence of): 98 nse i 23b. Did tobacco use contribute to the cause of death? detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. signed by t 3 Probably 4 Unknown 1 Yes 2 No Division of Vital Records, by 24b. Were autopsy findings aveilable prior to completion of ceuse of death? 24a. Wes an autopsy Completed page 2 s has 1 Yes 21 No 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physicien: funeral director, 25. Was cese referred to medicel examiner? 26. Place of Deeth (Check only one) Be Other: 4 Nursing Home 1 Yes 2No 5 Residence 6 □Other (Specify) 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28c. Injury at Work? 27. Manger of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred Certification: Natural 2 Accident 5 Pending 2 No 24 hours after deeth. investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medical (Check only one) within 2 To the 29b. Signature nd title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Item 23e) (Type, Print) e and aftress of pe

State Registrar 31. Date filed (Month, Day, Year)

32. Registra s Signature

B. Sparks



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year **Physician** TANNIE M. ONEIL May 1999 11:20PM /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore if Under 1 Year if Under 24 Hrs. Birthplace (State or Foreign Country) S( 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 10 M 20/F 65 30-4112 Yrs. Director Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ØYes 2 □ No NIA Directo MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code must be n 21207 KOAD Items 23a 4019 BARRINGTON USA Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 12. Was Decedent Ever in U,S Armed Forces? Race - American Indian, Black, White, etc. 11 Marital Status than "natural", or item the Medical Examiner 1 Yes 2 No if Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: à 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) DOMESTIC 1) OMESTIC LINKNOWN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be Mental MCMILLIAN ALEX MARIE ALLEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALFORD BALTO 21207 FLORA DAUGITTER BARRINGTON KD. Itam 27 4019 MD. Date Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Methed of Disposition Pages ъ important: If it any injury or o 1 Buriai 2 Cremation 3 Removal from State 5.31.99 BALTIMORE MO 4 ☐ Donation 5 ☐ Other (Specify) DRUID KIDGE CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO NATL PIKE BALTO 21229 ai 23a. Part1. Enter the discusse, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaf failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final diseese or condition resulting in death) /Medical neunoma **Examiner** Due to (or as a consequence of): Examiner UNG CANER physician and the burial-transit requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of): attanding ph for use as t ed by the a Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown by P S 24b. Were autopsy findings eveileble prior to completion of cause of death? should | 24a. Was an autopsy performed? Completed certificate has b 2 2000 1 ☐ Yes 2 ☐ No Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 28 No 7 1 Inpatient 2 □ ER/Outpatient 3 □ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: After 5 Pending investigation Natural aftar daath. | Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital or • Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier To the Hosp within 24 hor To the Fune complataly fi edical and manner stated. 29b. Signature and title of certain 29c. License number 29d. Date signed (Month, Day, Year)

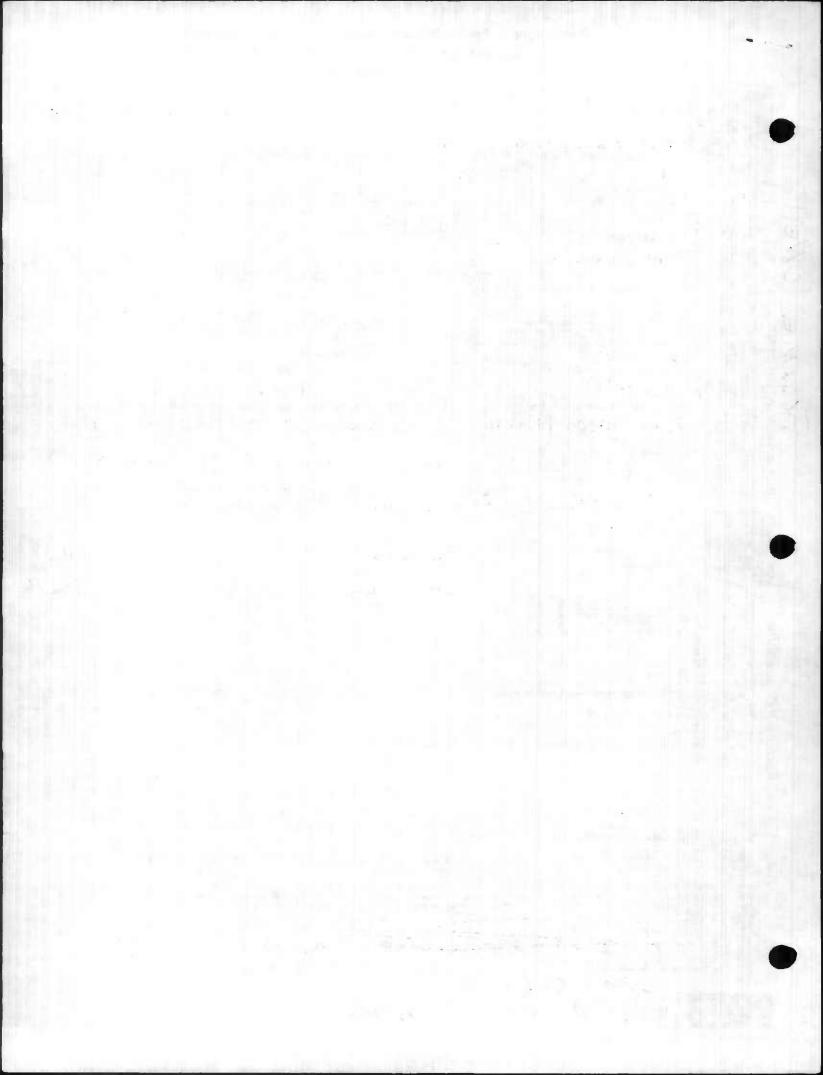
State Registrar 31. Date filed (Month, Pay Year) MAY 2 7 1999

Swam

2 CIBMC
32. Registrar's Signature

30. Name apd address of person who completed cause of death (Item 23a) (Type, Print)

Sporks



Elmer Olson

### Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

	AMEND IYEM#1 PER PHYS			nt of Health and N te of Death		Reg. No.	17	044	
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Funeral	5. Sociel Security Number 6. Se		lest birthday) If Und	er 1 Year If Under 24 Hrs.	8 Date of Birt	b	Mary 9. Birthola		
Funeral Director		M 20 F 94	∠ Yrs. Months	Days Hours Min.	Month, Da	y. Year) 5-1905		ice (Steta or Foreign y) S A	
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with page 1	50285 Male	one Bay Ct.		0628.		USA	Tiat Courti	y ·	
ofter death v r items 23s	11. Marital Status	12. Was Decedent Ever in U.	S. 13. Wes Dec	edent of Hispanic Origin? (Sp	ecify Yes or No	14. Raca	- America		
be filed within 72 hours effer death with the Maryland nat Hygiene.  ad other than "naturel", or items 23s or 23s-1 ehow event, the Medical Examiner mult be notified at the Completed by Funeral Director.	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Giva	If Yes, sp	ecify Cuban, Mexican, Puerto 2 No Specify:	Rican, atc.)		k, White, el		
ed within 72 hours of ygiene.  The fraction in the fraction of	15. Decedent's Ed	Year or Dates:	16a. Decedent's Us	ual Occupation		16b. Kind of Bu	siness/Indu	ustry	
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be filed tal Hygin d other event,	17. Father's Neme (First, Middle, Last)			18. Mother's Nam			a)		
should be nd Mental marked o	Carl Olson			Johanna					
d 2 should be file th and Mental Hy 7 Is marked oth traumatic event	19a. Informant's Name/Relationship (7			ss (Street end Number or Rui					
- 드림이는	Michael Olson/son		1/938 Che	erryfield Rd.	Date Date	20c. Location -	20630 City or Tow		
Pages nent of h	1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	emetery, cremetory or	other place)					
permit. Pages 1 e Department of Hes important: If hem eny injury or othe once.	4 ♣ Donation 5 ☐ Other (Specify  21. Signature of Funeral Service Ucon  Ronald S	4		and Address of Facility Anatomy Board	1, 655 W	V. Balti	more	Street	
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la porting	29a. Certifier Check only 2 Medical Exam	vsician: To the best of my kno iner: On the basis of examine	wledge, deeth occurre	d et the time, dete and place,	end due to the	ceuse(s) and ma	nner es sta	ated.	
To the Ho within 24 I To the Fu completel		and maring stated		9c. License number		29d. Date signed	1000000		
F M F S	29b. Signature and title of cartifier		2	A coar		-/	ala	0	
	30 Name and address of source	completed of the day of	23e) /Tuno Briet)	01/11/		5/1	77	7	
	JAMES BOYD M.	/	HOLLYWOOD M	10 A) VND , 30 6 3 E		,			
State	31. Deta filed (Month, Dey, Year)	A Regulirar's Signa		JULEVIAN 50033					
Registrar	MAY 2 7 1999	Ganara	4 /						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Zamoha 24, 1999 Ornelas 03:16 PM MAY /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** CITY THE JOHNS HOPKINS HOSPITAL BALTIMORE **Baltimore City** If Undar 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1□M 2 F Vrs 60 Director 520-36-6319 October 12, 1938 Wyoming Usual Residence of Decedent 10d. Inside City Limits 10a. Stata 10b. County 10c. City, Town or Location 1 Yes 2 No Director Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21045 U.S.A 5263Patriot Lane Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give 1 ☐ Yes 2 No Specify: Specify: American Indian à 3 ☐ Widowed 4 ☐ Divorced Yaar or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elamentary/Secondary (0-12) College (1-4or 5+) **US Government** Program Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Otto Hungary Fatima Iron 19a. Intormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7454 Hickory Log Circle Columbia, Maryland 21045 Mr. John P. Ornelas, Sr. Husband 20b. Place of Disposition (Name of 20a. Mathod ot Disposition Date 20c. Location - City or Town, State cematery, crematory or other place) Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 05/31/99 Friday Cemetery Ethete, Wyoming 21. Sign Jura of Funaral Service Licente 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 M00535 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart taitura. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finat Mypoventilation two hours disaasa or condition resulting in death) **Examiner** Due to (or as a consequence ot) Examiner Six months Tibrosi ulmonara Sequentially list conditions, it any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequenca ot): Physician/Medical Dua to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown pnermothorax à 24b. Ware autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No Be 25. Was case reterred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Medical Certification: To 1 [3 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No invastigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

requires that the death certificate be axecuted Box 68760 Records, P.O. Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifica completally filled in by the funeral director, I

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permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien, Important: If Nem 27 is marked other that any Injury or other traumatic event

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hours after

Baltimore, Maryland 21215-0020

the Medical Examiner must be nothing at

**DHMH 16 Ray 6/95** 

Registrar

State

29a. Certifier (Check only one)

29b. Signatura and title of certified

31. Date tited (Month, Day, Year) MAY 2 7 1999

Johns Hopkins Hospital Tower 110 600 North Wolfe Street Bultimore, Maryland 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Licensa number

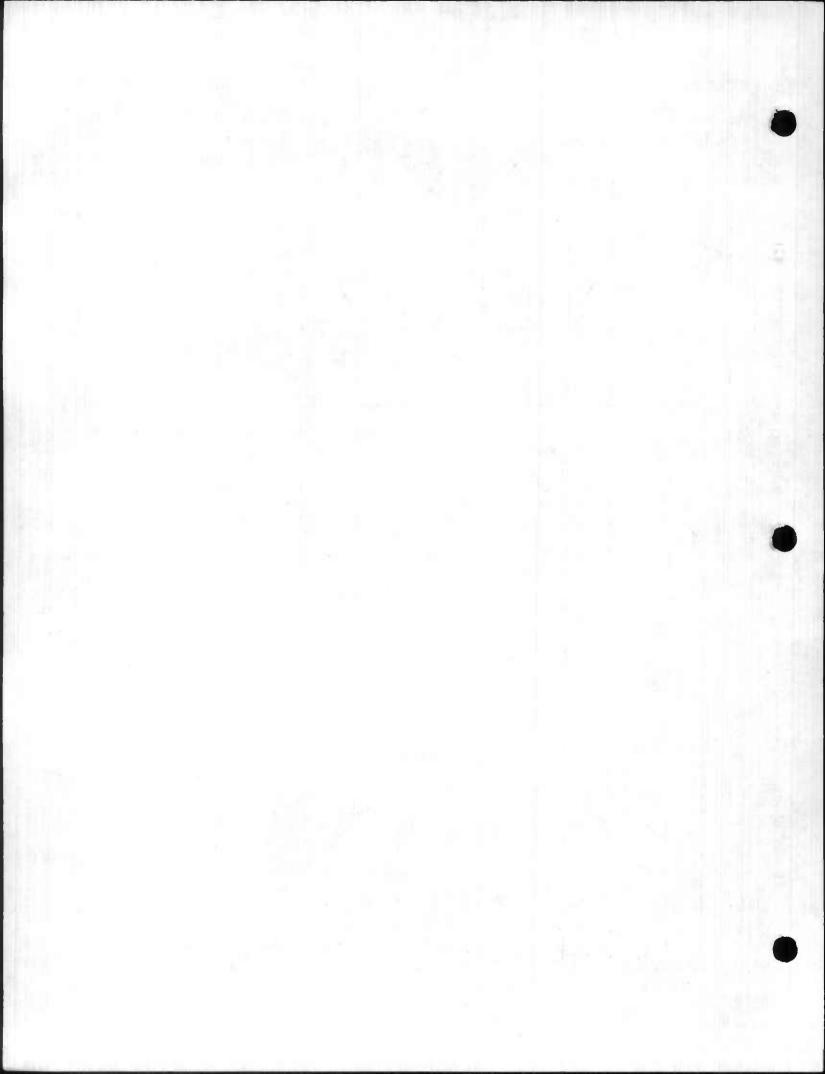
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Christopher Parsons, M.D.

29d. Data signed (Month, Day, Year)

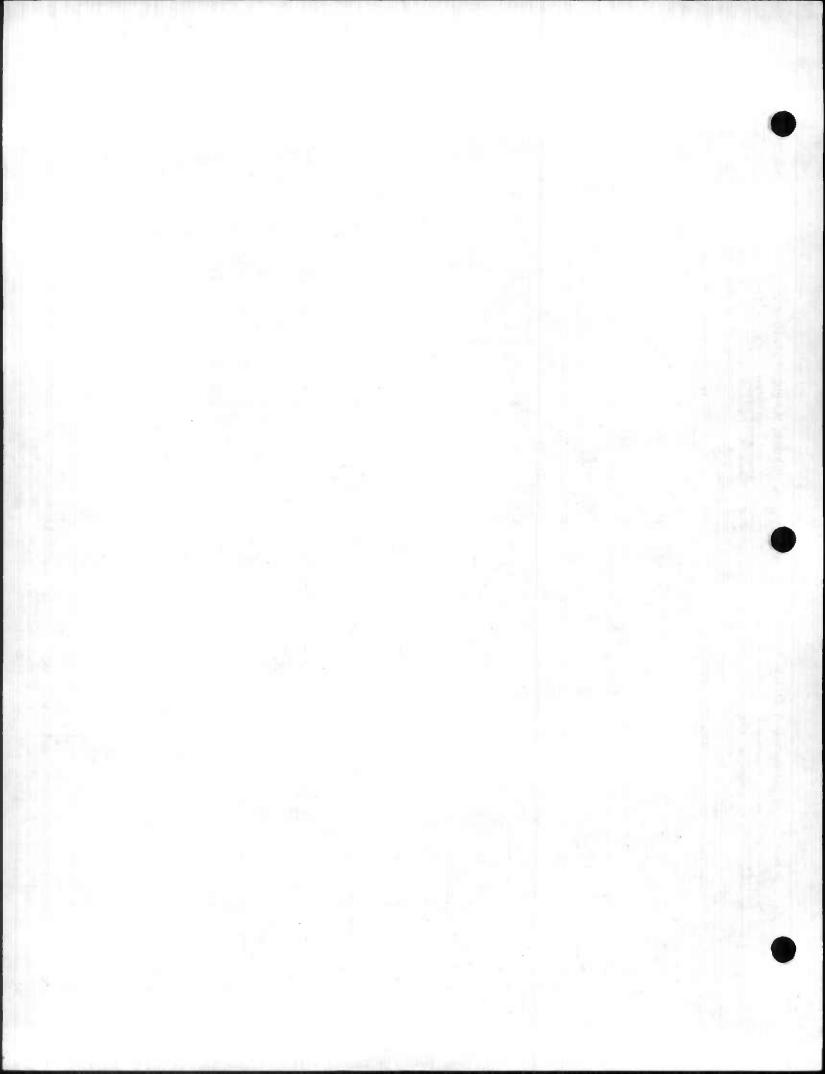
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May 24, 1999



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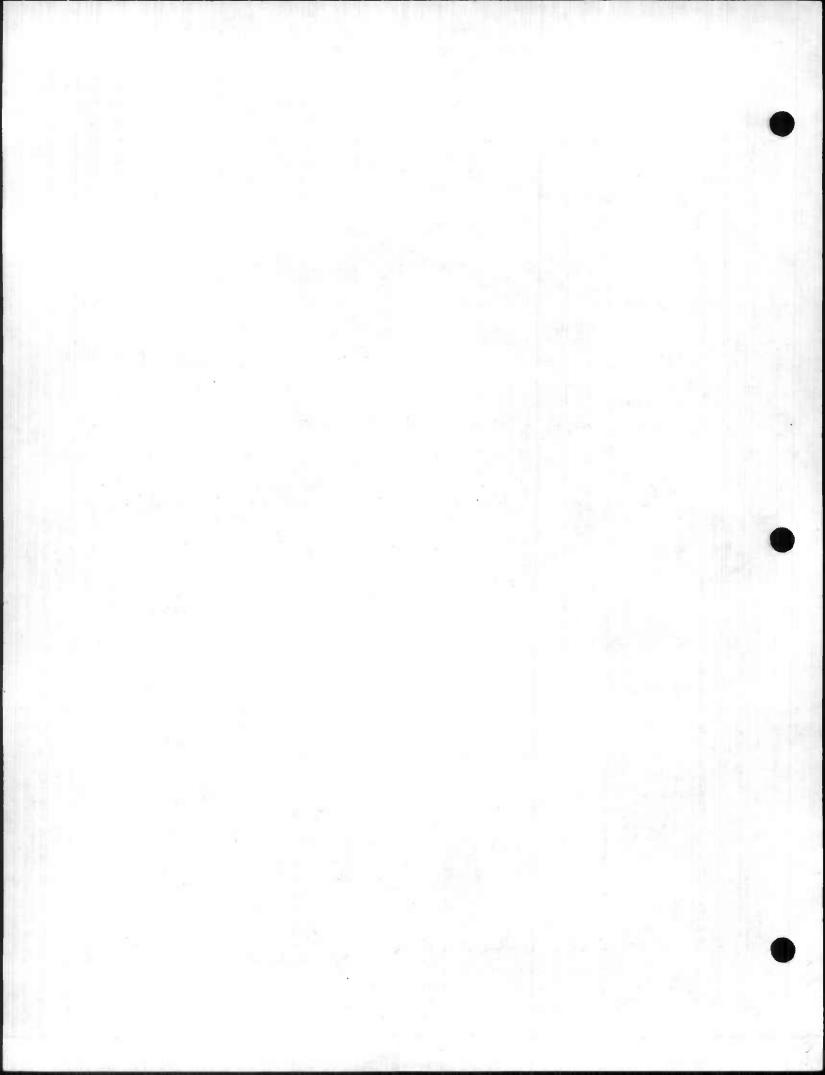
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L	/Medical	Anna C. Piotrowski			May	23, 1999	9:30 PM
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	Funeral Director		Months Days	Hours Min.	8. Date of Birth (Month, Day, NOV 23,	1924 Mar	hplace (State or Foreign untry) YLANd
	Auryland f show sd.st.	10a. State 10b. County 10c. City, Town or Locati	ion				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	or 28a-f sh be notified.	Maryland Harford Abingdon  10e. Street and Number	10f. Zip Code		11	Dg. Citizen of What Co	
	5 0 B D	123 Kensington Parkway	21009			u.s.A.	
Maryland 21215-0020	rat, or Herre 23 Examiner must 1 by Funeral	1 Never Married 2 Merried 1 Ves 2 No.	s Decedent of His es, specify Cuban Yes 2 🖾 No	spanic Origin? (Spec n, Mexican, Puerto F Specify:	cify Yes or No- tican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White	
5	od within 72 ho ygiene. wr then "neturn ft, the Medical.] Completed	15. Decedent's Education 16a. Decedent (Specify only highest grade completed) (Give kind	it's Usual Occupat	tion uring most of workin	a 1	16b. Kind of Business/	Industry
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Bug	Be see a	17. Father's Name (First, Middle, Last)		18. Mother's Name		faiden Sumame)	
ž	1 Ments	Joseph Crivello		Mary Pis			
Mai	12 sh					City or Town, State, 2	
6	Tang Part Part	Melvin A. Piotrowski (Son) 123 Ke	insingtor	n Parkway	7		21009
altimon	Pages mant of t ant: If the jury or of	20a. Method of Disposition  1 \( \mathbb{M}\) Burial 2 \( \subseteq \text{Cremation} \) 3 \( \subseteq \text{Removel from State} \)  4 \( \subseteq \text{Donation} \) 5 \( \subseteq \text{Other (Specify)} \)  Parkwood C	emetery	5	128/99	Baltimore,	Maryland
Ball	Deemil Depart Import any in	21. Signature of Funeral Service Licensee 22. N. S. C. M.	ame and Address	s of Facility Funeral Ho Phail Road	ome of l	Bel Air, I	nc. 21014
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one ceuse on each line.	he mode of dying	, such as cardiac or	respiratory arre	est, MV.	Approximate Interval Between
,00	Physician /Medical Examiner sthe pura-transit sthe pura-transit sthe pura-transit sthe pura-transit statement statem	Immediate Cause (Finel disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ATU nce of:	ry d	isean	ne >	2 4 cm
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O. E	death after after after siclar	Part II. Other eignificant conditions contributing to death but not resulting in the unde	rlying cause give	n in Part I.	23b. Did to	bacco use contribute	to the cause of death?
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Records,	been shoul				24a. Was ar perform	ned?	Were autopsy findings available prior to completion of cause of death?
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Viital	certificate rector, pag	25. Was case referred to medical		26. Place of Death			-34
>	Physician: this certific ral director, : To Be	examiner?  1 Yes No Hospitel: 1 Inpatient 2 ER/Outpatient	3 DOA Other			nce 6 Other (Spe	cifv)
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Division	tal or Attanding P rs after death. al Director: After to led in by the funers Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	, factory, office	2	8f. Location (Str City or Town	reet and Number or Re , State)	ural Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page Medical Certification: To Be Com	29a. Certifier (Check only one)  1 Certifying Phyeician: To the best of my knowledge, deeth oc 2 Medical Examiner: On the basis of examination and/or myest	curred et the time tigation, in my opi	e, date and place, a inion, death occurre	nd due to the ca d at the time, da	use(s) and manner as ate and place, end due	stated. to the cause(s)
	Within Toth Comp	29b. Signature and title of pertilities	29c License	27 36	25	9d. Date signed (Monte	h, Day, Year) — 99
			or Dr	. Sut	203	Touso	N MD 20 20
	State Registrar	31. Dete filed (Month, Day, Year) 32. Registrar's Signature MAY 2 7 1999	sport	W			



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Vee **Physician** Howard William Poole 24 1999 7:20 AM May /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Harford Mariner Health of Forest Hill Forest Hill If Under 24 Hrs 7. Age (In yrs. last birthday) If Under 1 Year 8. Dete of Birth (Month, Dey, Year) Birthplace (Stele or Foreign Country) **Funeral** Months Min. Deys Hours 1 X M 2 □ F 92 Director 213-10-2614 Aug. 1, 1906 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. inside City Limits 1 Yes 2 □ No Directo 288-4 Maryland Harford Bel Air the Medical Examiner must be notifi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or itsms 23a or 298 K Canterbury Road 21014 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian Bleck, White, atc. 1XXYes 2 No 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify à 3 ₩ Widowed 4 Divorced Yeer or Dates: 1923-26 White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry i filed within 7 i Hygiene. other then "r Elementary/Secondery (0-12) College (1-4or 5+) 9th grade Bus Driver Mass Transit d 2 should be filled with and Mental Hygie 7 is marked other ti 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked c any Injury or other traumstic eve. Thomas S. Poole Barbara Zeller 19e. Intorment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara L. Scholl (Daughter) 298 K Canterbury Road, Bel Air, MD. 21014 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 5/26/99 Lake View Mem. Park Sykesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Neme end Address of Fecility Schimunek Funeral Home of Bel Air, Inc. llen Ju Duran 610 W. MacPhail Road, Bel Air, MD. 21014 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediete Cause (Final disease or condition resulting in death) Examiner pue Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence ot) physician s the burial Box 68760. death certificate be Physician/Medical Due to (or es a consequence of): P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? á 1 Yaa 2 No 3 Probably 4 Unknown signed b Records, by 24b. Were autopsy tindings available prior to Completed 24e. Wes an autopsy performed? peeu completion of cause of death? certificate 2 No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: director, 25. Was case reterred o medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending i or Attending after death. Director: After 1 Tyes 2 □ No NIA Investigation 2 Accident 6 Could not be determined 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, term, street, fectory, office building, etc. (Specify) To the Hospire.
within 24 hours after or
To the Funeral Director of the Funera 4 I Homicide 29e. Certifier edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner steted. 29b. Signeture aphilitle of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bel Air, MD. Theresa Pete M.D., 2021 Emmorton Road, 21014 31. Dete tiled (Month, Day, Year) 32. Registrar's Signeture State - print MAY 27 Registrar

DHMH 16 Ray 6/95



Kevin Scot	t I	Peters		State	e of Ma	arylai				lealth and M Death		giene () Reg. No.		7048
		1. Decedent's Na	me (First, Middle	, Lest)					0.		2. Date of De			3. Time of Death
Physicia		Kevin S	cott Pet	cers							Month May 2	25, 199	9 Year	7:55 A.M.
/Medica Examine		4a Facility Name	(If not institution	giva street and	d number)					4b. City, Town, or L	-		ty of Death	
- Examina		West Bo	und Rout	e 32 at	t Rt.	3				Miller	sville	An	ne Ar	rundel
Funeral		5. Social Security	Number	6. Sax		a (In yrs	last birthday)		er 1 Year		8. Date of Bird (Month, Da		-	nplace (Stete or Foreign untry)
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ā bu		10a. State	10b. County			10c. C	ity, Town or Lo	cation						10d. Inside City Limita
eath with the Maryla ns 23e or 28e-f show mat be notified at	Director	MD	Anne Aı	rundel			Crofto	_						1 ☐ Yes 2 ☐ No
6 6 8	듬	10e. Streel and N	lumber					10f. Z	ip Code			f What Cor	untry?	
123a	ē		g Mill (						2111		US			
0 5 5	Funeral	11. Meritel Status		Arme	12. Wes Decedent Evar in U,S. Armed Forcas?			13. Was Decedent of If Yes, specify Cu		lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No Rican, etc.)	- 14. R	ace - Amer lack, White	rican Indian,
So all		****	rried 2 Marri	If Yes	es 2	lo		1 Ves 2 No Specify:					pecify:	
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To the season of	E I	Elementery/Sec	Colleg	ge (1-4or 5	+)		ve kind of work done during most of work a. DO NOT use retired)							
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Mar 12 sh 1 a m			Neme/Reletionsh	ip (Type, Print)						end Number or Ru				ip Code)
0 T W L	ŀ		Peters			Onto	1/03 Plece of Dispo			ct., Se				
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Limen Pa			5 Other (Sp			Mea	dowrid	ge M	em. F	Park 5, ess of Fecility Engton Bl	/29/99	lkrida	e. MD	21075
Physician /Medical Examiner		23a, Pert1. Enter shock, or he Immediate Cause disease or condit resulting in deeth	e (Finel				le In			ng, such as cardiac	or respiretory e	mest,	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Approximate Intervel Between Onset end Deeth
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Division  Of the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 ☐ Sulcide 4 ☐ Homicide	6 Could no determine	ned 286. P		ry - At h	oma, ferm, str	1	ry, office		28f. Location (: City or Tox		+322	4.11
Othe Hospital or ithin 24 hours afte o the Funeral Dir ompletely filled in		29a. Certifier (Check only one)	1 Certifying	xaminar: On th	the best one basis of	examine	wiedge, deeti	occurre	d et the tir n, in my o	me, dete end place, ppinion, deeth occur	end due to the red at the time,	cause(s) and i	manner es e, and due	stated. to the cause(s)
o the vithin 2 ormple		29b. Signature ag	d itle of certifier	10	2			2	9c. Licens	e number		29d. Date sign	ned (Month	n, Day, Year)

	d
t II. Other algnificant conditi	one contributing to death but not resulting in the underlying cause given in Pert I.

29b. Signature and little of certifier

29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) May 25, 1999

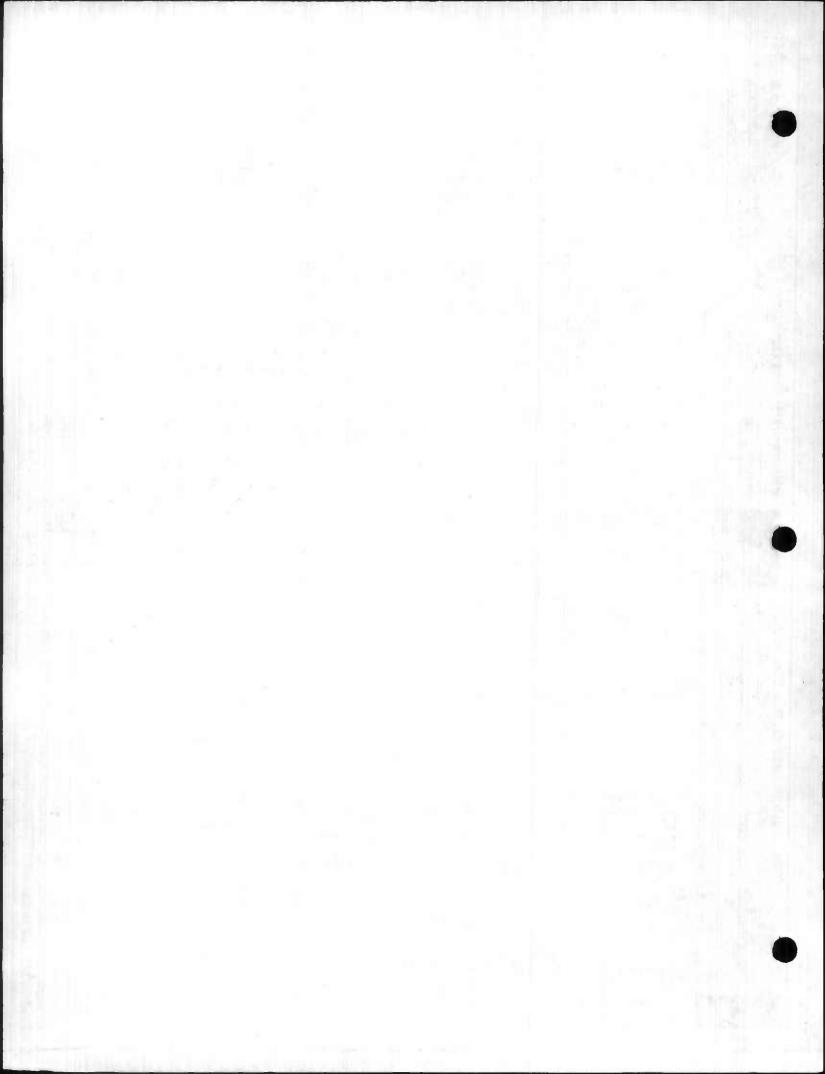
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VennisJ

111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Year)





Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:10AM KICHARDSON /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Franklin Square enter K Hospital Ce
7. Age (In yrs. lest birthday) OSECI If Under 24 Hrs. da imort 8. Date of Birth (Month, Dey, 03-28 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 12 M 20 F Months Days Hours Min 218.16.1137 Yrs NC Director Usuai Residence of Decedent Maryland 21215-0020 Hinley Pages 1 and 2 should be filed within 72 hours efter death with the Manylend neet of Health and Mental Hyglene. Intit if Items 21s or 25s-f ehow nnt: if Items 27 is marked other than "naturel", or Items 23s or 25s-f ehow any or other treumatic event, the Medical Enaturel man be notified any or other treumatic event, the Medical Enaturel man be notified as 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No NIA Director MD BALTIMORE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 2208 ARK USA VENUE Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritai Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: þ BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coilege (1-4or 5+) Shippin 3 LONG SHOREMAN 8 TH GRADE NIA 18. Mother's Name (First, Middle, Meiden Surneme) 17. Father's Name (First, Middle, Last) KICHAROSON MARY **HOMAS** HARRIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Belationship (Type, Print) permit. Pages 1 and 2 Depertment of Health a Important: If Item 27 Is any injury or other tre once. PARK KICHAROSON DOROTHY WIFE 2208 SALTO. mo. Baltimore, I 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 6-1-99 BALTO. 4 ☐ Donation 5 ☐ Other (Specify) VOODLAWN CEMETERY 21. Signature of Funeral-Service Licensee 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL 5151 BACTO NATL' PIKE, BALTO. MD. 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** /Medical immediate Cause (Final 10 Years disease or condition resulting in death) Examiner Examiner ulmonal attending physician end for use es the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequenca of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequenca of): is signed by the ail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Renal 1 Yas 2 No 3 Probably 4 Unknown Stage à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy Hypertension is certificate her 1 Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certificatiely filled in by the funeral director, g 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Realdence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Sulcide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Placa of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Mospital of within 24 hours of To the Funeral D completely filled. Cartifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pieca, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Drive Baltimore, MD 1000 Franklin Square

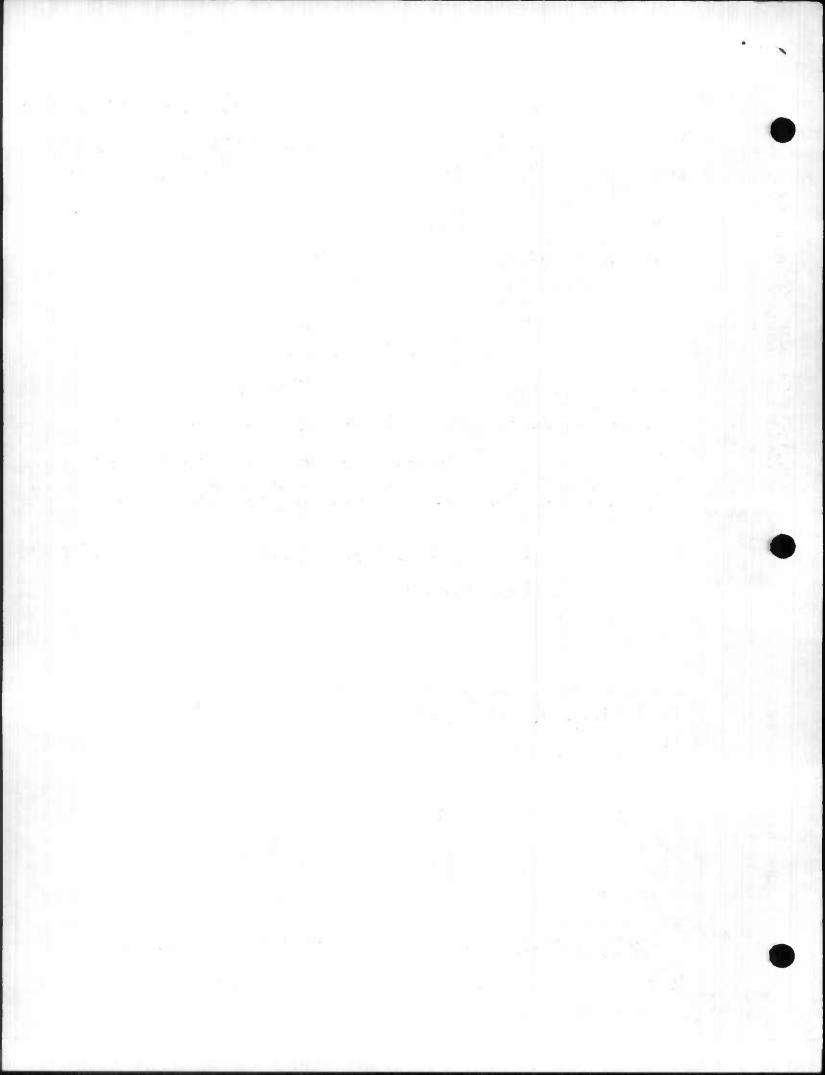
State

Registrar

Kenneth 31. Date filed (Month, Day, Year) MAY 2 7 1999

32. Registrar's Signature

**DHMH 16 Ray 6/95** 



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Dev Year MARIE ANN ROLNICK 4b. City, Town, or Location of Death 1999 /Medical 05:30 AM 4a Facility Neme (If not institution, give street end number) 4c. County of Death Examiner HERITAGE NURSING CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1□ M 257 F Director 216-01-3264 90 Feb 3,1909 MD Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits show 1 Nes 2 No Director 28a-f MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or USA 1400 DELVALE AVENUE 21222 Funeral r than "naturel", or liens the Medical Examiner na 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2**K** No If Yes, Give 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 □ Divorced WHITE Year or Detes: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) SEAMSTRESS 6 GARMENT WORKER 7 is marked other traumetic event, 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FRANCIS CAROLYN WASIK DOMBROWSKI 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health at Important: if them 27 is any injury or other trau 1400 DELVALE AVENUE, BALTIMORE, MD 21222 BERNADINE COLES 20a. Method of Disposition

Buriel 2 Cremetion 3 Removel from State 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State HOLY ROSARY CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) May 231999 BA 2TO, MD 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility
KACZOROWSKI FUNERAL HOME 1201 DUNDALK AVENUE, BALTIMORE, MD 21222 acyoroush 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervat Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical DIABETES MELLITUS **Examiner** Physician/Medical Examiner DEMENTIA sician and burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last The law requires that the death certificate be exe P.O. Box 68760, ERGLYCEMIA

Due to (or es a consequence of): for use as the HYDRATION Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Were autopsy findings available prior to completion of cause of death? page 2 ahould Completed 24a. Was an eutopsy certificate has 1 🗆 Yes 2 PM 1 ☐ Yes 2 D No of Vital Physician: director. edical Certification: To Be 25. Was casa referred to medical 26. Place of Deeth (Check only one) Other: 45 Nursing Home 5 Residence 6 Other (Specify) nours after death.

neral Director: After this or
y filled in by the funeral dire Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 27. Menney of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division or Attending 5 Pending investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in foreitying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.

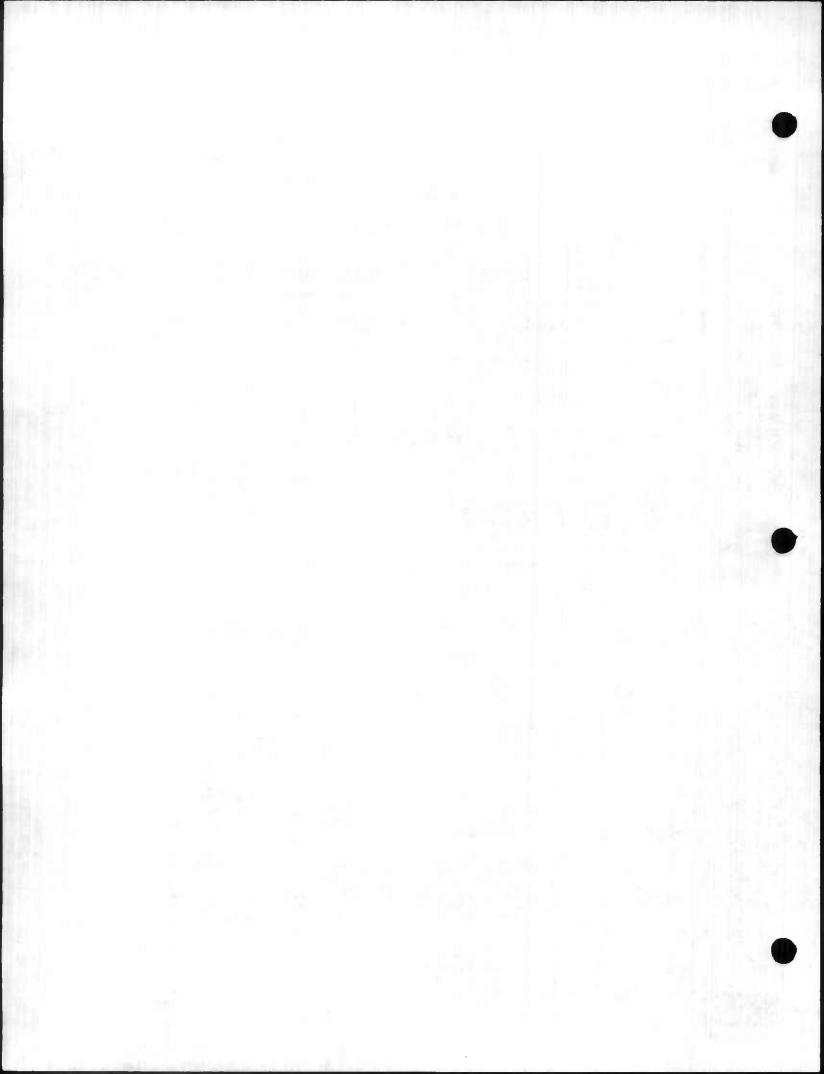
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. 29e. Certifier 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Dete filed (Month, Dey, Year)

DHMH 16 Rev 6/95

32. Registrer's Signature

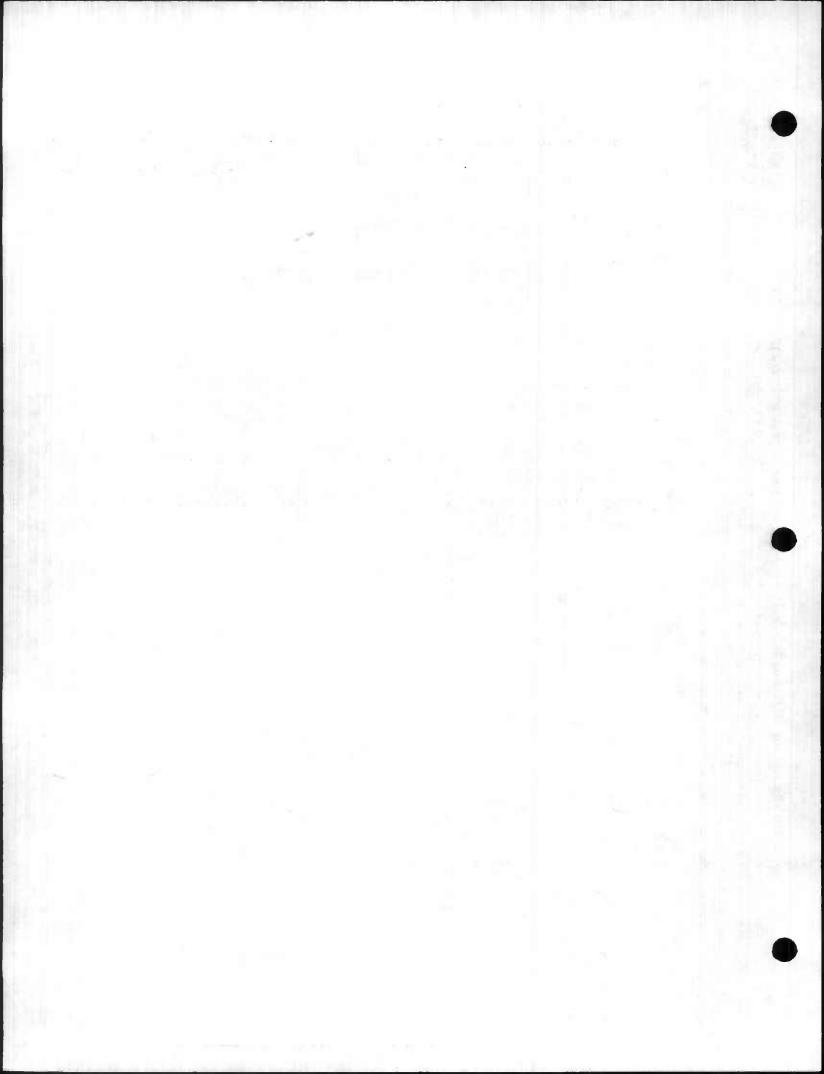
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

				Cei	rtificate c	f Death	1	R	leg. No.	18. 7	DUL	
	1. Decedent's Nama (First, Mid	dla, Last)					- 1	2. Date of Dea Month		Year	3. Time of Death	
Physician	Otelia C. Stinnett May 20, 1999										4:30am	
/Medical Examiner	4a Facility Nama (If not instituti	ion, giva street and nu	ımber)			4b. City, To	own, or Le	ocation of Death	4c. County	of Death		
CXUIIIIICI	Manorcare H	lealth Serv	vices (Fa	alls F	Road)	Ba1	timo	re	N/A			
Funeral	5. Social Security Number	6. Sex	7. Age (In yrs. la		If Under 1 Ya	ar If Under	24 Hrs.	8 Date of Birth	1	9. Birthol	lace (State or Foreig	117
Director	234-20-9956 Usuel Rasidance of Decedent	1□ M <b>X</b> XF	98	Yrs.	Months Da	ys Hours	Min.	Sept 2	9, 1900	Vir	ginia	
ž u	10a. State 10b. Coun	ly	10c. City,	, Town or Lo	cation					10	0d. Inside City Limit	5
or thems 23e or 28e-f show miner must be notified at Funeral Director	Maryland N/	/ A	D	altimo	240						1⊠Yes 2□N	0
be notified Directo	Maryland N/ 10e. Street and Number	A	D.	artime	10f. Zip Cod			1	log. Citizen of W	font Count	ln/2	
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by	1 Never Merried 2 Married 3 Widowed 4 Divorced  1 Yes 2 XNo If Yes, Giva Year or Dates:				1□ Yes 2∏	io Specify			Specify:	Whit	e	
Completed	15. Decede (Specify only high		16a. Dece	dent's Usual Oc kind of work do DO NOT use re	cupation ne during mo:	st of work	ing	16b. Kind of Bu	siness/Ind	lustry		
du	Elementary/Secondary (0-12)	College (	(1-4or 5+)									
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Be	17. Father's Neme (First, Middle	e, Last)						a (First, Middle,	Maiden Sumam	e)		
2	Harry Ga	arrett				5	Sally	Dudley				
	19a. Informant's Name/Ralation Charles H. Co							more, M				
	20a. Mathod of Disposition		20b. Pla	ace of Dispo	osition (Nama of metory or other)			Data	20c. Location -	City or To	wn, Stata	
	1 ☐ Burial 2 ☐ Cremation 4 ☐ Donetion 5 ☐ Other	Lynchbu	ourg, Virginia									
DOCS.	21. Signature of Juneral Service	Gense Co	route	4	2. Name end Ad Burgee-1 3631 Fai	Henss-S	Seitz	z Funera Baltimor	1 Home,	Inc land	21211	
	23a. Part1. Entar the process, shock, or haart famous. Li	or complications thet	ou wed the death.	. Do not ent	ter the mode of	dying, such as	cardiac	or respiratory arr	rest,	i	Approximata Interval Between	
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	resulting In death)	a/		as a consec							o day	
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xam	Sequantially list conditions, if any, laading to immediata cause. Enter Underlying	6.	Due to (or	es a consec	quence of):						1	1
edicai Examiner	cause. Enlar Undarlying Cause (Disease or Injury that initiated events resulting in death) Last  Dua to (or es a consequence of):											
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detached for use	Part II. Other significant condit	ions contributing to d	leath but not rasul	Iting in the u	nderlying cause	given in Part	l.	23b. Did to	obacco use con	tribute to	the cause of deat	17
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Medical Certification: T	29b. Signature and title of certif	-	/	7	29c. Lic	ense number		- 2	29d. Data signed	(Month, i	Day, Year)	
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-	Circum	- I have	4			730	16		5 00	1		
	30. Name and address of perso	n who completed cau	sa of death (Item :	23a) (Type,	Print) 773つ	5	11.	Ro-	5-20 Bult	M.D	717/1	
CANA	31. Dete filed (Month, Day, Yea	1 225	Registrar's Signetu	ure	1 1	1 0	-VLC	124	- wet	1/6	0,01	
State legistrar		27 1999	The state of the s	a /	9. pp	all	-					



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Day Year Gilbert Stafford May 22 1999 5:10pm Η. 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Towson Baltimore Co. Gilchrist Nursing Home If Under 1 Year If Undar 24 Hrs. 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) 5. Social Sacurity Number 8. Date of Birth (Month, Dey, Year) **X** M 2 F Months Days Hours Min Yrs. 03 68 217-26-1173 M.D Usual Residance of Dacedent 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 XYas 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1810 Edmondson 21223 Ave U.S.A. 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, atc. 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: If Yes, Give Yaar or Datas: Specify: Black 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Self Employed 12th grade Home Improvement 18. Mother's Name (First, Middle, Meiden Sumeme) Unk 17. Father's Name (First, Middle, Last) Carroll Stafford Frances 19a. tnformant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Tracye Stafford-Daughter P.O. Box 164, Columbia, Md 21045 20a. Method of Disposition 20b. Piaca of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 1 ☐ Buriai 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/26/9 Baltimore, Md Metro Crematory Inc 22. Name and Address of Facility March F/H West 21. Signature of Funeral Sandon License 4300 Wabash Ave, Baltimore Md 21215 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only end cause on each line. Approximata interval Between Onsat and Death

**Physician** /Medical Examiner

that the death certificate be axecuted

P.O. Box 68760.

Division of Vital Records,

certificate

this

After

death.

Hospital or Attend 24 hours after death Funerel Director: /

To the Hospital or within 24 hours aft To the Funeral Di completaly filled in

Attending Physician:

Item 27

**Physician** 

/Medical

Examiner

Funeral

Director

notified

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Funeral

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May 22, 1999

physician and tha burial-transit ò signed by the page 2 funera

Examiner Physician/Medical by eted Certification:

Immediate Cause (Final

disaase or condition resulting in death)

2 months ON CAncer Due to (or as a consequence of) Due to (or as a consequence of): Due to (or as a consequence of)

Balto. md. 2120x

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Part It. Other signiffcant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performad? completion of cause of death? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Hospice 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 Neturel 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) and manner statad. 29a. Certifier 29b. Signature and title of certifier 29c. Licensa number 29d. Date signed (Month, Dev. Year)

edicai

31. Date filed (Month, Day, Year)

. A. Kiley

GBMCU 6701 N. Charles St. 32. Registrar's Signature

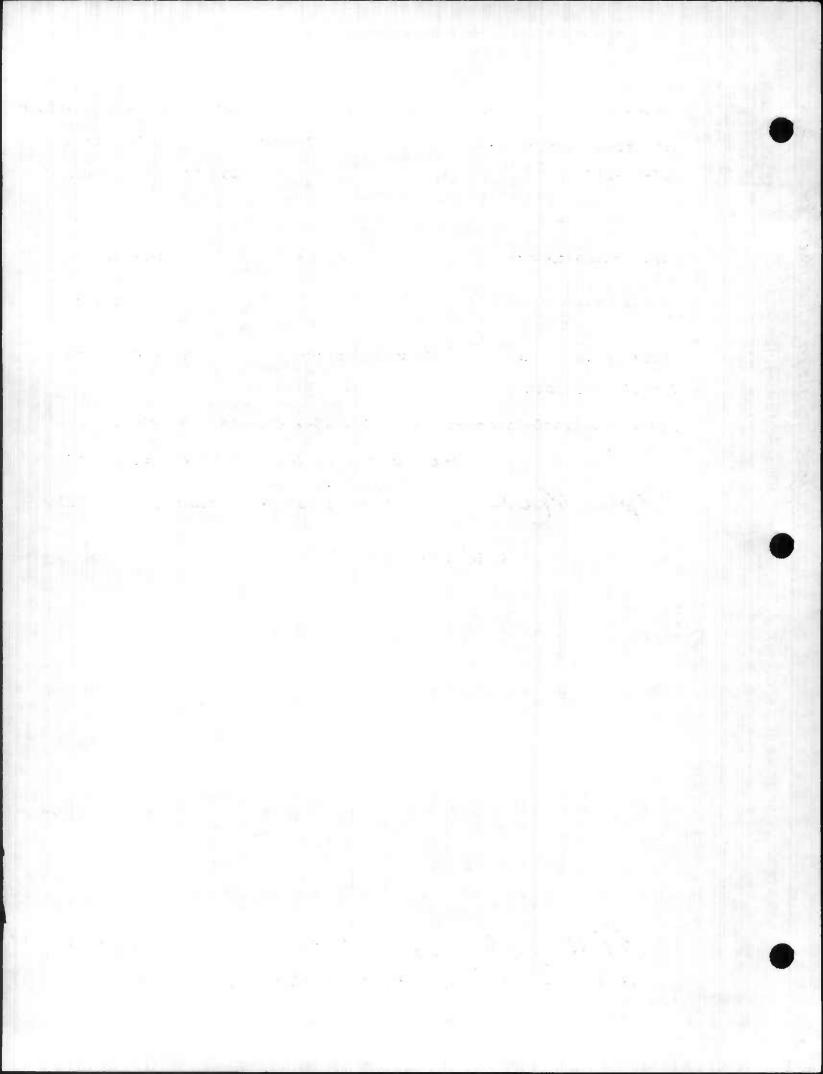
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MAY 2 7 1999

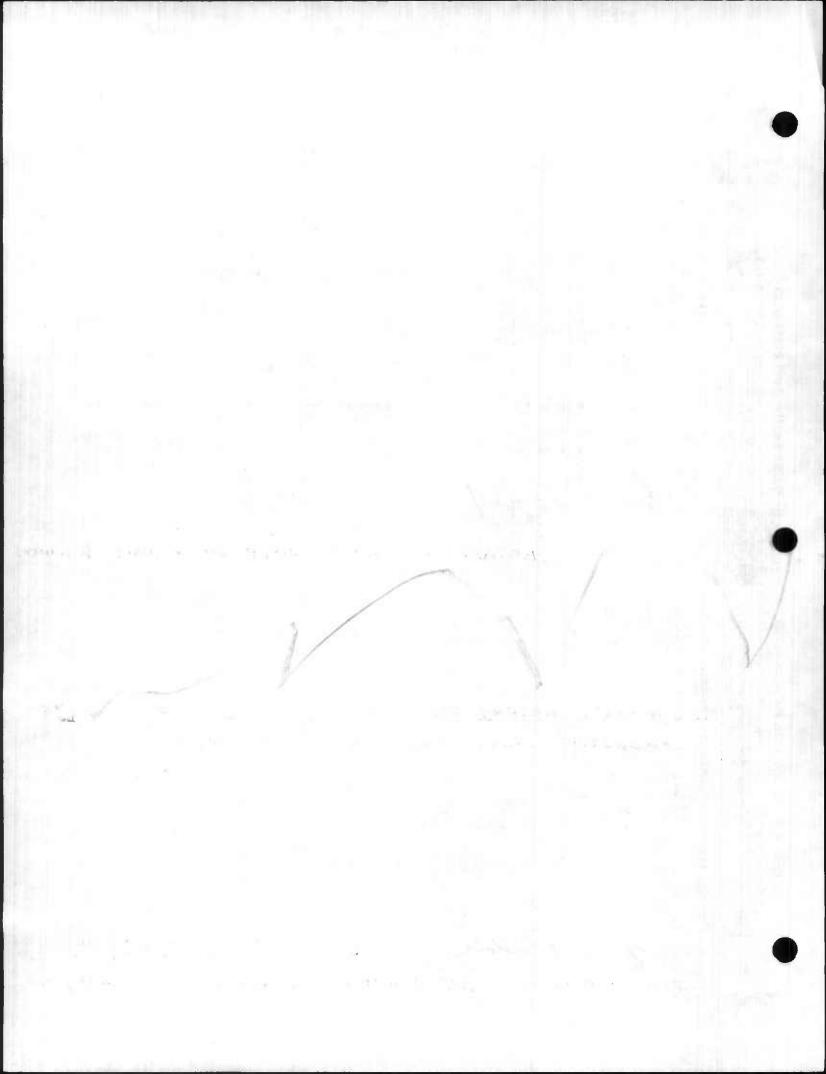


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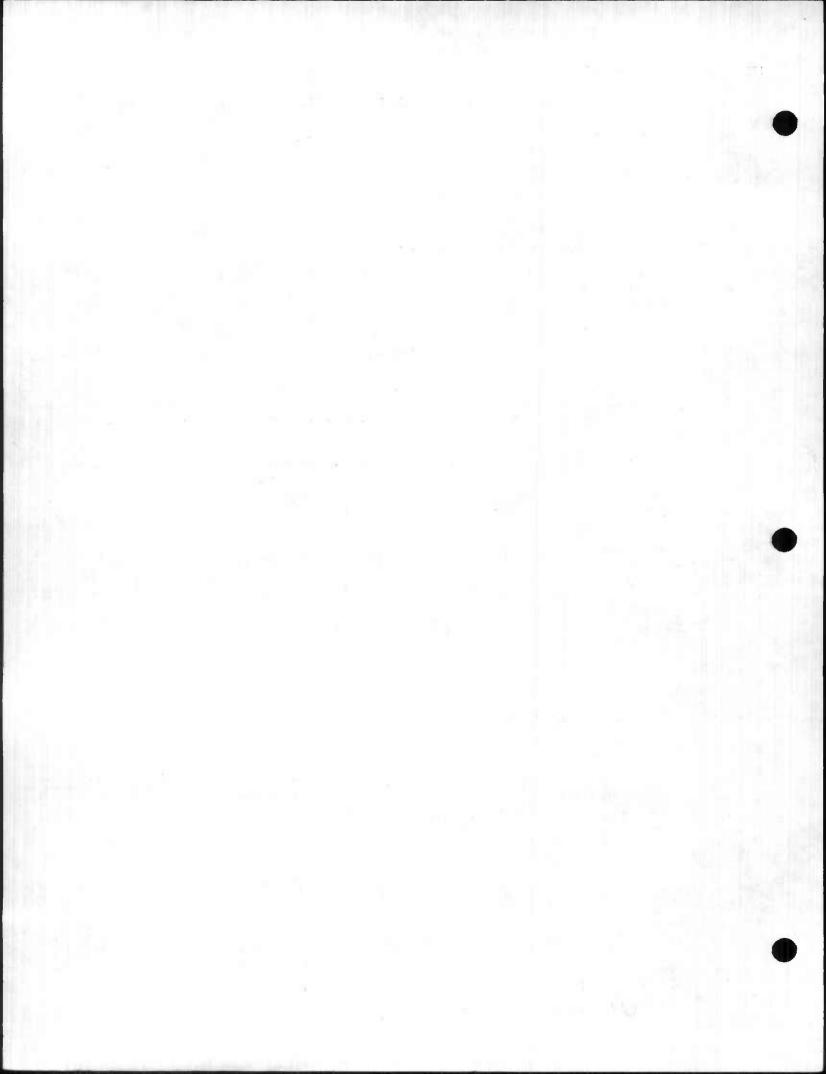
State Registrar



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4a Facility Name (						4b. City, Town, o	Apr 1 Location of Dea		ty of Death	03:00 P	
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5. Social Security N		S. Sex	7. Age (In yr	s. last birthde	Months Day			irth	9. Birth	place (State or For	
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										1 ☐ Yes 2 ☐	
MD 10e. Street and Nu	mber		BA	LTIMO	10f. Zip Code			10g. Citizen of What Country?			
	TEV CMD				21221		USA				
7017 CON 11. Marital Status 1 Never Marr	DEI SIK	12. Was Dece	edent Ever in	U,S. 1	3. Was Decedent of	Hispanic Origin?	Specify Yes or No- 14. Race - Ame				
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	ame/Helationship BUCHACZ	ρ (τ <b>γρθ, rπnt)</b>			eiling Address (Street 017 CONLE)						
20a. Method of Dis			20b.	Place of Dis	sposition (Name of		Dete	20c. Location			
		Removel from	State		cremetory or other pi	21					
21. Signature of Fi	5 Other (Speciment)		-	101000	22. Name end Add		Apr211999	BAI	LTIMO	ORE , MD	
16	P	7	/		KACZOROWSI	KI FUNERAL					
Mona	as 1	1 passon	-M		1201 DUNDA	ALK AVENUE	BALTIMO	RE, MD 21.	222		
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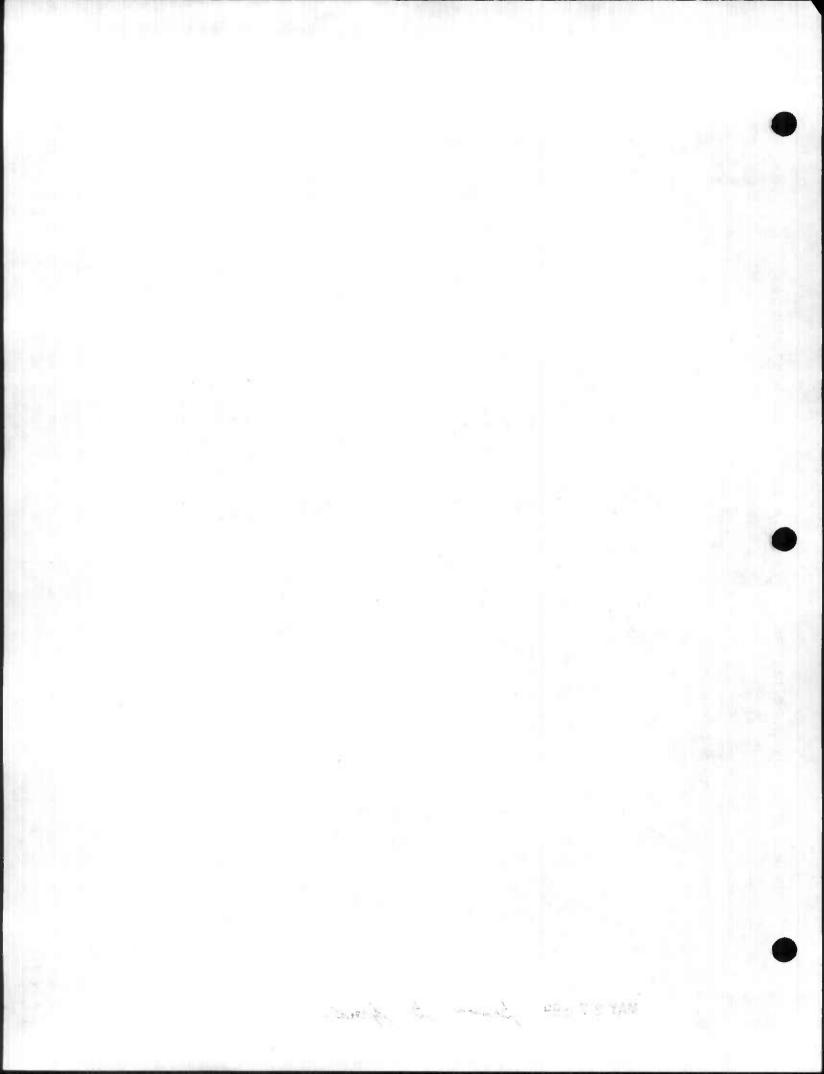


	ITEM: #1 P	State of Mary ER MD G771 5-28-99 WR.	land / Department of F Certificate of I		rgiene Reg. No.	17054				
	Physician /Medical	1. Decedent's Name (First, Middle, Last)  Lattice M SAMU	CLS LILLIAN M. SAM	AUELS 2. Date of De Month	Day Year 22 1990	3. Time of Death 3 - 13AM				
	Examiner	4a Facility Name (If not institution, give street and number) HOWARD COUNTY GENERAL HOSPITA		tb. City, Town, or Location of Deat COLUMBIA	th 4c. County of Dea HOWARD	th				
	Funeral Director	244-32-6040 1 M 2 MF	89 Yrs. Hist birthday) History 1 Year Months Days	Hours Min. 8. Date of Bit (Month, Dit AUG. 1	orth Year) 9. Bird Co.	thplace (Stete or Foreign buntry) DRTH CAROLINA				
	Jend Jend	Usual Residence of Decedent  10a. State 10b. County 10	c. City, Town or Location			10d. Inside City Limits				
	r 28a-f ahow notified at	NEW YORK BRONX	BRONX			1 Yes 2 □ No				
	\$ 0 K D	10e. Street and Number 1278 CLAY AVENUE, APT. 3A, E.	169th ST 104. Zip Code	56	10g. Citizen of What Co					
020	hours effer deeth v ural', or home 23e Exemple med d by Funeral	11. Merital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	rin U,S. 13. Was Decedent of H If Yes, specify Cubs 1 ☐ Yes 2√√No	lispanic Origin? (Specify Yes or No an, Mexican, Puerto Rican, etc.) Specify:	Black, Whit					
1215-0020	ed within 72 horygiene. Ar than "natural, to the Medell	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usuel Occup (Give kind of work done life. DO NOT use retired	during most of working d)	16b. Kind of Business					
d 21	other to	+2 17. Father's Name (First, Middle, Last)	DOMESTIC WORK	XER 18. Mother's Name (First, Middle	CLEANING  Maiden Sumeme)	SERVICE				
Maryiand	754 m		MOFFATT	AMANDA		HARR				
Jar	2 sho	19a. Informant's Name/Relationship (Type, Print)		and Number or Rural Route Numb						
	s 1 and 2 should I Health and Man tem 27 la marke other traumatic	MARY L. SAMUELS (DAUGHTER)  20a. Method of Disposition	Oh Place of Disposition (Name of	NUE, APT. 3A, E.	169TH ST., BI					
aitimore	Page H: H	tX Burial 2 ☐ Cremation 3 ☐ Removal from State	Cemetery, cremetory or other place GLEN HAVEN MEMORI	09)						
Bait	pemit. Pa Departmen Importanti any Injury paca.	21. Signature of Funeral Service Licensee	22. Name end Addre	ss of Fecility SINGLETON AVENUE, S.W., GL	FUNERAL HO	ME, P.A.,				
	Physician	23a. Part1. Enter the disease, or complications that caused the shock, or heart fellure. List only one cause on each line.	death. Do not enter the mode of dying	ig, such as cardiac or respiratory a	irresi,	Approximete Interval Between Onset and Death				
4	/Medical Examiner		etal Preu	monia		4 weeks				
	n and lat-transit	b. Osle	omyelitis - lef	+ greater +	rochamter	4 beeks.				
8760,	cate be executed physician and the buriet-transit dical Examir									
Box 68	thet the death certificated by the attending pridetached for use esti					1				
	the att	Part II. Other significant conditions contributing to death but no	en in Part I. 23b. Did	23b. Did tobacco use contribute to the cause of death						
s, P.O	es that the igned by th be detache by Phys	Dementia			1 Yes 2 No 3 Probably 4 Unknown					
Records,	een s hould	Dementiq Hypertension			ormed?	Were autopsy findings available prior to completion of cause of death?				
	The law pate has b page 2 s			10	Yes 212 No	1 ☐ Yes 25 No				
Vitai	Physician: The This certificata rai director, pag	25. Was case referred to medical examine?	OT FREE POINT OF DOA OTH	26. Place of Death (Check only						
o	Z 00 C	1 Yes 2 Yo To Inpatient  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation  1 Inpatient 28a. Date of Injury (Month, Day Ye)	28b. Time of linjury Wor	4 I Nursing Home 5 II Hes	idence 6 Other (Spe how injury occurred	ecity)				
Division	tail or Attending P rs after death. In Director: After t led in by the funer Certification:	2 Cuinida 6 Could not be	At home, farm, street, factory, office (pecify)		(Street and Number or Rown, State)	lural Route Number,				
	To the Hospital or Attending Physics A hours after death. To the Funeral Director: After the Completal filled in by the funeral hombies of the Certification: Medical Certification:	29a. Certifier (Check only ane)  12 Certifying Physician: To the best of my ane)  13 Certifying Physician: To the best of my and manner steted.	y knowledge, death occurred at the tin mination and/or investigation, in my o	ne, date and place, and due to the pinion, death occurred at the time,	cause(s) and manner a , date and place, and du	s stated. e to the cause(s)				
	within Toth room	29b. Signature and title of the Committee Comm	29c. Licens	30469	29d. Date signed (Mon May 2	11. Day, Year) 220 1999.				
		30. Name and address of person who completed cause of death 9055. CHEVROURT PRIVE 19	(Item 23a) (Type, Print) N' E	FUELLANKI	10.210	42				
	State Registrar	31. Date filed Mooth, Day, Year, 1949 32. Hegistrar's 3	Signature G. Sparks	)						



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician	1. Decedent's Name (First, I		st)					2. Date of De Month		Year	3. Time of Death
/Medical	Thelma	B			Steel	9	4b. City, Town, or	May		999	8:00 a.
Examiner	4a Facility Name (If not insti						_	Location or Deati			
	Howard Cour  5. Social Security Number	nty G		Spital ge (In yrs. la:		Jnder 1 Yea	Columbia	8. Date of Bir	Howard		nca (State or Forei
Funeral Director	446–14–9213 Usual Residence of Deceder	1	□M 2∯F	77		nths Days		(Month, Da	12, 1922	Count	rv)
ž =	10a. State 10b. Co			10c. City,	Town or Locatio	n				10	d. Inside City Limi
the day	MD Ho	ward		E11	icott C	ity					1 ☐ Yes 2 ☑ N
r tems 23s or 28s-f single-from the motified	10e. Streef and Number 9786 Micha	els V	Way		10	of. Zip Code 2104	2		U.S.A.	hat Count	ry?
by E.	11. Marital Status 1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Divo		12. Was Deceden Armed Forces 1 Yes 28 If Yes, Give Year or Dates	? ] No :	101	'es 2 ☑ No			Black	- America k, Whita, a Whi	itc.
tal Hygiene. d other than "natural syent, tre medical Be Completed	15. Dec (Specify only h Elementary/Secondary (0-			5+)	16a. Decedent's (Give kind lifa. DO N		pation a during most of wo ad)	rking	16b. Kind of Bus		ustry
Hygin H	17. Father's Nama (First, Mic	ddie Last)			Homema	ikei	18 Mother's Na	na /First Middle	Maiden Sumame		
and Mental I	Lewis Bale							di G. Ba		,	
th and M	19a. Informant's Name/Rela Martha B.			er)			ot and Number or Ri 1s Way, E				
Department of Health Important: If Itam 27 any injury or other tr pncs.	20a. Method of Disposition 1 ☑ Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth	tion 3 🗆	Removal from State	20b. Pla	nce of Disposition metery, cremator SCO Ceme	(Name of y or other pl	ace)	Date	20c. Location - 0	City or Tov	wn, State
Departm Importar any inju	21. Signature of Funeral Ser		-	3.1			ress of Facility Wi				
ing physician and as the burial-transit  Medical Examiner	resulting In death)  Sequentially list conditions, If any, leading to immediate causa. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last	{	b	Due to (or a	as a consequence as a consequence as a consequence	e of):	ure	L			week
stending p			J								
d by the strendin letached for uss Physician/N	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Congestive heart Failure								tobacco use con Yes 2□ No	3 Prob	
been signe should be c	Criges)	VC	newer	rail	ure				an autopsy ormed?	ava	ra autopsy finding ilable prior to appletion of cause leath?
s certificate has director, page 2 To Be Comp								10	Yes 20 No	1	Yes 2 No
ector, ector,	25. Was casa rafarred to me examiner?	dical					26. Place of De	ath (Check only	one)		
2 2	1 Yes 2 No		Hospital: 1 Inpat	tient 2 El	R/Outpatient 3	LI DOA			idence 6 Othe		)
rs after death.  al Director: After to led in by the funera  Certification:	1 Natural 5 Pe 2 Accident in 3 Suicide 6 Co	ending vestigation ould not be stermined	(Month, D	ay Year)	Injury A ne, farm, street, f		Yes 2 No		Street and Number		t Route Number,
within 24 hours aftar of To the Funeral Direct completaly filled in by Medical Certifi	29a. Certifier 1 ☑ Certifier (Check only 2 ☐ Med		yelclan: To the besiden: On the besiden	t of my knowle	ledga, death occ			a, and due to the	cause(s) and mai		
thin 2 mplel										(Month, I	Day, Year)
<b>₹</b> 8	. 6		MO								- 41
	-			death (Item 2	23a) (Type, Print		053636				
State Registrar	30. Name and address of periods of the state	rson who of the form of the fo	complated causa of CARLO	death (Item 2	23a) (Type, Print 3460 ET Ire G.						

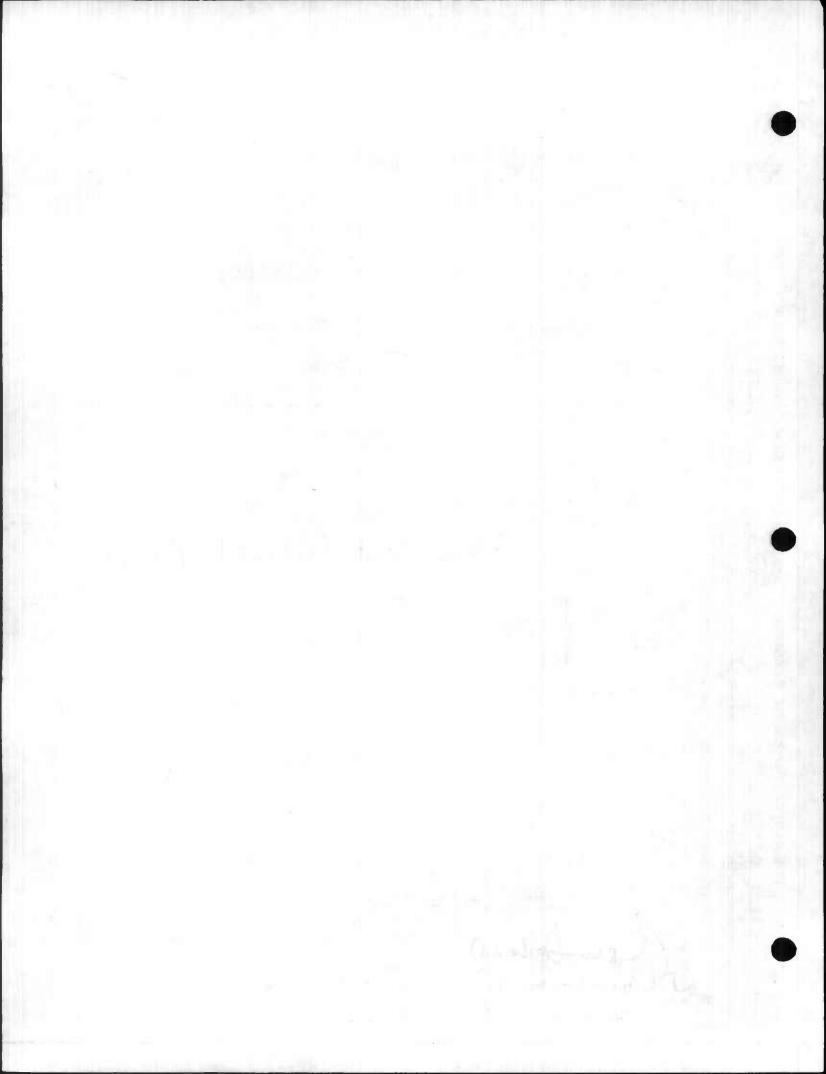


WRC 99-2326-510 AMOS SPELLMAN

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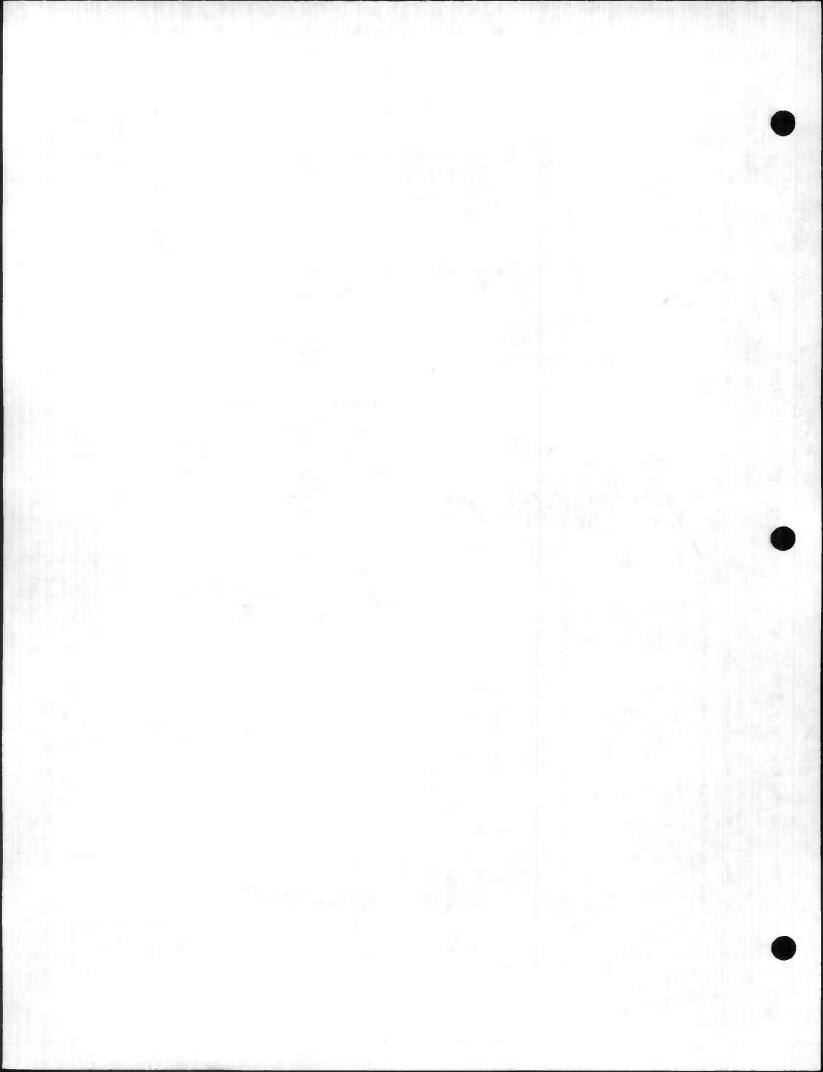
State of Maryland / Department of Health and Mental Hygiene

PELLMAN			y laira / L	Certifica	te of	Death	Dev .	ı. No.		7 0 00 00	
	1. Decedent's Neme (First, Middle,	Last)					2. Date of Death	-	177	3. Tima of Death	
Physician	Amos Spellma	n					Month APRIL 2	Day 2, 199	Year	4:07 PM.	
/Medical	4a Facility Name (If not institution,					4b. City, Town, or Le		4c. County		4:07 PM.	
Examiner	1428 MADISON						IMORE	4c. County	or Death		
Funeral Director	5. Social Security Number unknown	IMM STE	(In yrs. lest bir	thday) If Under Months	r 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) unknown	(ear)	9. Birthpl Count unkno	ace (State or Foreign	
-	Usual Residence of Decedent						Juli Lillow II		dilitile		
show dat	10a. State 10b. County		10c. City, Tow	or Location					10	Od. Inside City Limits	
or 28a-f st be notified Director	Maryland		Baltin	nore			1000			152 Yes 2 □ No	
9 0 8 0	10e. Street and Number			10f. Z	p Code		109	. Citizen of V	Vhat Count	ry?	
	1428 Madison Av	enue			2120			unknown			
5-0020 72 hours sher death 172 hours (or heme 23 dical Examiner must) sted by Furneral	11. Marital Status Unknown 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Wes Decedent Endemoder Forces?u. d 1 Yes 2 No. If Yes, Give Year or Dates:	nknown	1000	2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - America :k, White, s		
ted isali	15. Decedent's	Education	ducation 16a, Decedent's Usual			ation	. 10	Sb. Kind of Bu	usiness/Ind	ustry	
1 21215-0 ad within 72 ho splans. ar than "natur 4, the Medical, Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed)  College (1-4or 5+		(Give kind of w life. DO NOT	ork done ise retire	during most of work d)	orking				
21 an	unknown	unknown						resi	denti	al	
y, mallyiding AIA 10-0020 and 2 should be filed within 72 hours at alth and Mental Hygiene.  7 is marked other then "natural", or ar traumatic event, the Medical Exam To Be Completed by F	17. Father's Name (First, Middle, L	nst)		18. Mother's Name (First, Middle, Meiden Surname)							
	unknown					unknown					
	19e. Informent's Neme/Relationsh	p (Type, Print)	19b	Mailing Addres	s (Street	and Number or Run	al Route Number,	City or Town,	Stete, Zip	Code)	
	unknown		unknown								
O Tage	20a. Method of Disposition		20b. Place of	Disposition (Na	me of		Date 20	c. Location -	City or Tov	wn, Siele	
Baltimore, semil. Pages 1 a separtment of Han mportant: If Item my injury or othe sock.	1 Burial 2 Cremation 4 Donation 5 Other (Sp.	ocity)in state	cemetei	y, crematory or							
Ban Depa	21. Signelure of Funeral Service L Ronald	S. WAde, Di	rector	State	Anat	omy Board MD 2120		Balti	more	Street	
Physician /Medical Examiner	23a. Pan 1. Enter the disease, or of shock, or heart tellure. List of the limit of	· Ate	enos		ie	Cardina			as e	Intervel Between Onset and Deeth	
cords, P.O. Box 68760, v requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burtal-transit.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that imitated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):										
Box attending for use		d									
rords, P.O. Box requires that the death cert seen signed by the attending hould be detached for use, sted by Physician/M	Part II. Other significant condition	contributing to death but	contributing to death but not resulting in the underlying cause given in P					acco use co	ntribute to 3 ☐ Prob	the cause of death?	
Vital Records, idean: The lew requires the certificate has been signe rector, page 2 should be a Be Completed by							24a. Wes an performe	autopsy ed?	ava	re autopsy lindings lilable prior to appletion of cause leeth?	
The He House							1 ☐ Yes	20 No	1	Yes 2□ No	
Vital Rec	25. Wes case referred to medical					26 Place of Deat	h (Check only one				
Of Vita Physician: this certific ral director,	examiner? 1 XYes 2 No	Hospital:	t 2 ER/Ou	tpatient 3 D	OA OU	MONE"	ome 5 Pesiden		er (Specific		
Division of Vital Re To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	27. Manner of Death  1 D Natural 5 Pending 2 Accident investige	28a. Date of Injury (Month, Day			28c. Injui Woi		28d. Describe how			)	
Division of the or Attending P is a fee death.  al Director: After the ded in by the funeric Certification:	3 Suicide 6 Could no 4 Homicide determin	A 286. Place of injur	00 00 00 00 00 00 00 00 00 00 00 00 00					28f. Location (Street and Number or Rurel Route Number, City or Town, State)			
To the Hospital within 24 hours To the Funeral Completely filled	29e. Certifier 1 Certifying 2 X Medical E	Physician: To the best of carniner: On the basis of e	examination and	, death occurred Vor investigation	at the tire, in my o	ne, date and place, pinion, death occur	end due to the cau red at the time, dat	se(s) and ma e and place,	anner as stand due to	ated. the cause(s)	
To the within To the comp	29b. Signature and title of certifler	Lolem		25		e number	29d. Dete signed (Month, Day, Year) APRIL 23, 1999				
	30. Name and addoles of person w	no completed cause in dee	111 I		eet,	Baltimor	re, Maryl	and 21	201		
State Registrar	31. Date liled (Month, Day, Year) MAY 2 7	1999 32 Registrar		B. A.							



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 7.05.7

				State o	f Marylan		artmei ertifica				lental Hy	giene Reg. No.		001	
		Physician	Decedent's Nama (First, Middle	1100.5	Bernard	Sulliv	/an				2. Data of De Month	Day	Year	3. Tima of Death 12:01 PM	
4		/Medical Examiner	4a Facility,Nama (If not institution			<u> </u>		1	4b. City, T	own, or Lo	ocation of Deat	1ay 22, 199 4c. County		12.01110	
		LXummer	St A	gnes Nursing	& Rehah C	enter				Ellic	ott City		Ho	ward	
		Funeral	5. Social Security Number	6. Sex,	7. Age (In yrs. I			er 1 Year		r 24 Hrs.	8. Data of Bir (Month, Da	th		laca (Stata or Foreig try)	חק
		Director	237-05-8593	M 2DF	8	4 Yrs.	Months	Days	Hours	Min.		5, 1915		rth Carolina	
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12		vith the Mar to 28a-f at the notified Director	Maryland	Howard					Columb	oia				1 □ Yas 2 No	
3		Dir.	10e. Street and Number				10f. Z	ip Code	0.4	1044		10g. Citizen of			
ulliva		iter death with the Marylar r items 23s or 28s-f show other must be notified at Funeral Director	5537 Green Dory L		dent Francis III	6 40	Was Dag	national and the		1044		14 Pag	U.S.		
-		Hem Hem	11. Marital Status 1 □ Nevar Married 2 □ Marr	Armed Fo		5. 13.	Il Yas, sp	ecity Cubi	iispanic O an, Mexica	ngin? (Span, Puarto	ecify Yas or No Rican, atc.)	Bia	ck, Whita,		
13	20	urs of	3 Widowed 4 □ Divorced	If Yas Giv	/a		1 Ves	20 No	Specify	<i>r</i> :		Specif	y:	White	
9)	9	filed within 72 hours effer death with the Maryland hygiene. Wher than "natural", or flems 23s or 28s-f show ent, the Medical Exeminer must be notified at a Completed by Funeral Director	15. Deceden	t's Education		16a. Dece	edent's Usi	ual Occup	ation			16b. Kind of B	usinass/Inc	Justry	
,	215	led within 72 ho ygiene. wr then "neture it, tre Medical Completed	(Specify only highas Elemantary/Secondary (0-12)	collega (1	-40r 5a)	(Give	DO NOT	ork done use retired	during mo d)	st of work	ing		14:11 0	P	
a	21	Hiled with Hygiene. Wher the	8	Conega (	-401 047				Sales				Mill Su	pplies	
	land	be filed d other event,	17. Fathar's Nama (First, Middla,	Last)					18. Moth	ner's Name	(First, Middle	, Ma <i>iden Sum</i> ar	ne)		
>	yla	snould be and Mentel is marked or sumatic even	James	Garfield Sulliv	van						La	ura Bell Ki	me		
N	Mary	and and and and	19a, Informant's Name/Ralations	hip (Type, Print)		19b. Mail	ing Addres	ss (Street	and Numb	ber or Run	al Routa Numb	er, City or Town	State, Zip	Code)	
~	-	s 1 end 2 f Health tem 27 l	Ms. Bonnie Dar	niel Da	aughter				ory La	ne Col	,	ryland 2104			
2	0		20a. Mathod of Disposition  1 Burial 2 Cramation	3 Ramoval from	a	lace of Disp	ematory or	other place	ce)	i a a l	Data	20c. Location			
0	t m	tant:	onation 5 Othar (S	pecity)		North Ca	Comr 2. Name a				05/24/99	Winston-	Salem,	North Carolina	а
	Baltimore	permit. Pages Department of Important: If it any Injury or ones.	27. Signature of Furtiral Service	Liceriseé		2					РΔ				
		40244	Memebeller	Steel	moos							tt City, MD	21043		
		Physician /Medical Examiner	Part 1. Enter the disease of shock, or heart lailure. List Immediate Causa (Final disease or condition resulting in death)	0	REBRI		VAS	cui		1	Λ	DENT MORRA	0.5	Approximata Interval Between Onsat and Daath	
		be executed bician and puriel-transit	Sequentially list conditions	b	Dua to (or	r as a conse	quence of	):	/ \ 101		HAC	MORKE	146		
	0	requires that the death certificate be executed seen signed by the attending physician and should be deteched for use as the bunel-transited by Physician/Medical Examireted by Physician/Medical Examire	Sequantially list conditions, if any, laading to Immadiata causa. Entar Undarlying Cause (Diseasa or Injury					300							
	8760,	ohysician the burie	that Initiated avants rasulting in death) Last	C	Dua to (or	as a conse	quence of)	:					1		
	9	nding p use as													
	Box	attending   for use as		0											
	o.	at the death certific d by the attending platched for use as Physician/Me	Part II. Other significant condition	ns contributing to de	eath but not resu	liting in the	underlying	cause giv	en in Part	1.	23b. Dld	tobacco uss co	ntributs to	the causs of death	1?
w	0	that the de by the detached	DIABETT	25 M	ELLITA	15					10	Yss 2 No	3 Pro	pably 47 Unknow	MU
MACHI	Records,	signed ld be d by	7								24a Was	an autopsy	24b. W	are autopsy findings	-
9	00	The law require cate has been so page 2 should Completed	DEMEY	ITTA.								ormed?	co	nilable prior to mpletion of cause death?	
4.	Re	The law ate has b page 2 sl										v		_/	
	Vital	certificate rector, pag	25. Was casa ralarred to medical						OC Die	( D+)	10		110	Yes 2/21No	
			examiner?	Hospital:	npatient 2 🗆	ER/Outpatie	ent 3 D	OA Oth	var /		n (Check only	dence 6 □Ott	ar /Snacif	4)	
	of	2 2 2 7	27. Manner of Death			28b. Tima	-	28c. Injur Wor				how injury occur		//	_
	Ю	Attending R or death. ector: After by the funer iffication:	1 Natural 5 Pendin 2 Accidant invastig		n, Day Year)	Injury	M		k? Yas 2□	] No					
	Division	Attend or death ector: / by the ifficat	3 ☐ Suicida 6 ☐ Could I 4 ☐ Homicida datarm	ined 20a. Flace	of Injury - At ho	me, farm, s	treet, lacto	ry, office			28f. Location (		ber or Rura	l Routa Number,	
	Ö	s after d il Direct ed in by	4 Tromoda	Dullali	ng, atc. (Specify	"					City of To	wii, Siata)			
		To the Hospital or Attending P within 24 hours after death: To the Funeral Director: After completely filled in by the funeral Medical Certification:	29a. Certifier Certifyin (Check only one)	g Physician: To the Examiner: On the ba	isls of examinati	wledge, dear ion and/or in	th occurred	at the tin	ne, date a pinion, de	nd place, eth occurr	end due to the ed at the time,	cause(s) and m data and place,	anner as s	ated. the cause(s)	
		ithin ithin on the omple	29b. Signature and titla of certilias	and mann	ioi stateu.		29	c. Licens	e number			29d. Data signe	d (Month.	Day, Year)	
1		6 3 € 8		1/01	· Oin.			N	200	90		P	100	>	
1			30. Name and address of person	who complated caus	a ol death (tto-	23a) (Type	Print\	100	LON	17		5/24	1017	0	
			TACNAM	AKH	ANI	722	20	KA	Rie	1	EICOSI	73 A	VE	BALTO	)
1		State	31. Data liled (Month, Day, Year)	32. R	egistrar's Signat	tura 4	do	21/2	/		//	, - , ,	n	11) 2/20	P
X		Registrar	MAY 27	1999		1.	1700	- Way							



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URSHINSK.

7. Age (In yrs last birthday)

10c. City. Town or Location

BALTIMORE

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

If Under 1 Year

Months

Days

Assure	All Coples	Are Leg	ible.	\
ealth and	Mental Hyg	jiene		7058
Death		ea. No.	1	1000
	2. Date of Dea Month	th Day	i de q	3. Time of Death , Lf 30 Am
. City, Town, or	Location of Death	4c. Count	y of Death	
BALTIMO	RE	N/A		
If Under 24 Hr Hours Mir	O. DETO OI DITT		Cou	placa (State or Foreign ntry) YLAND
	- 4			10d. Inside City Limits  XXYes 2 □ No
	1	0g. Citizen of USA	What Cou	ntry?
spanic Origin? ( n, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	Bla	ce - Ameri ick, White, iy:WHIT	
tion uring most of w	orking	16b. Kind of E	lusiness/Ir	dustry
		UNKNO	٧N	./
18. Mother's Na	ame (First, Middle,	Meiden Surna	me)	
FANN:	IE		(U	NKNOWN)
nd Number or F	Rural Route Number	r, City or Town	, Stete, Zi	o Code)

21208

Approximate interval Between Onset and Death

4b. City, Town, or Location of Death

filed within 72 hours after Baltimore, Maryland 21215-0020 Pages 1 and 2 should be

Box 68760

P.O.

Division of Vital Records,

Hospital

within 2 To the

**Physician** /Medical Examiner

AMENDED ITEM #26 PER M.D. G77115/27/99 AH

LEVINDALE

5. Sociel Security Number

219-07-9665

10a. State

Usual Residence of Decedent

**Physician** /Medical

Examiner

**Funeral** 

Director

show.

258-1

herns 23s or

"natural", or

Hygione.

Important of Health and Mental Hygi-important: If Item 27 is marked other any Injury or other to

the Manfand

1. Decedent's Name (First, Middle, Last)

STHE

10b. County

N/A

4a Facility Name (If not institution, give street and number)

6. Sex

1 M 2 F

Examiner physician and s the burial-transit the death certificate be executed Physician/Medical attending p **\$** signed by t þ page 2 should b certificata or Attending Physician: Be edical Certification: To this After death. n 24 hours after death.

Ne Funeral Director: A pletely filled in by the fu

Directo 10e. Street and Number 10f. Zip Code 10g. Citize 2500 W. BELVEDERE AVE. 21215 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 272 No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 11. Merital Stetus 1 Never Married 2 Married 1 Yes 2XNo Specify: S by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind Elementary/Secondary (0-12) College (1-4or 5+) UNKI CLERK 18 Mother's Name /First Middle Meiden S 17. Fether's Name (First Middle Last) Be THOMAS DAVID TURSHINSKY FANNIE 19b. Meiling Address (Street and Number or Rural Route Number, City or 19a. Informant's Name/Relationship (Type, Print) 2500 W. BELVEDERE AVE., SUITE 107 MRS. DORI DONNER (SOC. WORKER) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
KNESSETH ISRAEL ANSHE
KOLK CONGREGATION 20a. Method of Disposition Date 1 XBurial 2 ☐ Cremation 3 ☐ Removel from State 5/10/99 BALTIMORE MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS. INC. ) sce 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or as a consequence of) Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 LNO 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 LNc 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Watural 5 Pending 1 Tyes 2 No investigation 2 Accident

State Registrar

completely

31. Date filed (Month, Day, Year) MAY 2 7 1999

3 Sulcide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signature end title of certifier

HAROLD

6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BOB

25 32 Registrar's Signature

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Des terdan

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steted.

29c. License number

DURING YES

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			Decedent's Nama (First, Mid	dla, Last)		Certificate of	f Death	2. Date of Dea			3. Tima ot Death
	Physic		GEORG	E.	тс	AKIRIS		Month MAY	Day 25	Year 1999	
	/Medi Exami		4a. Facility Name (If not instituti			WILLID	4b. City, Town, or L		4c. County	9111	6:30PM
1	Exami		RIVER	RVIEW CARE CE	NTER		BALTIMO	2 F		IMORE	
	Funeral	ŕ	Social Security Number	6. Sex 7. Ag	e (In yrs. last b	irthday) If Undar 1 Yea	If Under 24 Hrs.				ice (Steta or Foreign
	Director		213-09-3968 Usual Residance of Dacedent	1 <b>∑</b> [M 2□F	94	Yrs. Months Day	s Hours Min.	8. Date of Birth (Month, Day Sept. 2	o 1904	GI GI	eece
	ylan		10a. State 10b. Count	*	_	wn or Location				10	d. Insida City Limits
	Ma F	cto	Md. Balt:	imore	Essex	ζ					1 ☐ Yas 2 HNo
	th th	ire	10e. Street and Number			10f. Zip Coda			l0g. Citizan ot \	What Counti	y?
	23a	aic	One Eastern	Blvd.		2122	21		U.S. o	of Am	erica
0200-91212	filed within 72 hours efter death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ther, the Medical Examiner must be notified at	by Funeral Director	11. Maritai Status  1 Navar Married 2 Ma  Widowed 4 Divorce	If Yes Give		13. Was Decedent of It Yes, specify Cu		acify Yes or No- Rican, atc.)	14. Rac Blac Specify	e - America ck, White, e Whi	tc.
5	72 ho	Completed	15. Decede	ent's Education	168	. Dacedent's Usual Occi	upation		16b. Kind of B	usinass/Indu	stry
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7	filed within Hygiene. Ither than	E O	3	NA	Pı	coprietor			Rest	ıaran	t
9	be filed ital Hyg d other event,	Be	17. Father's Name (First, Middle	, Last)			18. Mothar's Nem	e (First, Middle,		,	
la I		To	Emanuel		Tsaki	iris	Chrysa	anthy	Ţ	JNKNC	NW
Maryiand	d 2 should be f th end Mental I 7 is marked of traumatic eve		19a. Intormant's Name/Relation		hter 19	b. Mailing Address (Stree	et end Number or Rur	el Route Numbe	r, City or Town,	Stete, Zip (	Code)
	7 5 4 5 7		Chrysanthy Ko	ootsikas	50	916 Linthi	cum Lane	Linth	icum.	Md.	21090
ב	of Healt litem 2 r other		20a. Method of Disposition		20b. Place (	of Disposition (Neme of ery, cramatory or other pi		Date	20c. Location -		
	D = - 0		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		Oak 1		000)	May E	ast Po	oint,	Md.
pariminore,	mit. Pa cartmor cortant: rinjury 8		21. Signature of Fugifical Seryipi		1		ress of Facility				
č	Page 18		DA 110	100	-1		ress of Facility ki-				
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	Physician /Medical Examiner	er	Immadiata Cause (Final disease or condition resulting in death)	· Myoc	cardi	al gru	foret	oy			nterval Between Onsat and Death
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6	rtificate be executed ng physician and es the buriel-transit	Examiner	Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or Injury		Due to (or as a	consequence ot):					
	siciar buri		Cause (Disease or Injury that Initiated events	C							
	ficate phy s the	Medical	resulting in death) Last		Due to (or as a	consequence of):				1	
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	The ate h page	50						1□ Y	es 2000No	1 🗆	Yas 25 No
	ysician: The is certificate director, pag	Be	25. Was cesa reterred to medica examiner?	al			26. Place of Deat	h (Check only on	ie)		
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	ding Pt h. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pandi	28a. Date ot Injur (Month, Day	y 28b.	Time of 28c. Injury		28d. Describe ho			
	Attanding ir deeth. octor: After by the fune	atic	2 Accident Invest	tigation			Yas 2□No				
	or Attandent efter deet Director: f in by the	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homlcida detarr	not be nined 28a. Place of Inju building, atc	ury - At home, ta (Specify)	arm, street, factory, office	)	28t. Location (St City or Town		er or Rurel i	Route Number,
	To the Hospital or Attanding Ph within 24 hours eliter deeth.  To the Funeral Director: Afler thi completely filled in by the funeral	edical C	29a. Cartifiar 11 Cartifyi (Check only one) 2 Medicel	ng Phyaiclan: To the best of Examiner: On the basis of and mannar sta	examination ar	a, death occurrad at tha t nd/or investigation, In my	ima, date and place, opinion, death occurr	and due to the co	ause(s) and ma ata and place, a	innar as stat and due to t	ed. ne cause(s)
	of this of the office of the o	Me	29b. Signature and title of certific			29c, Licar	isa number / /	/ 2	9d. Date signa	d (Month, De	ev. Yeer)
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Physician /Medical	1. Decedent's Name (First, Middle			Certificate of		2. Date of Dear			3. Time of Death
	Robert	Lee WA	1Ker	JK,		Month MAY 2	3, 1999	Year 9	0201 AM
Examiner	4a Facility Name (If not institution JOHNS HOPKINS				4b. City, Town, or I BALTIMO		4c. County	Of Death/	4
Funeral Director	5. Social Security Number 218-60-8556 Usuel Residence of Decedent	6. Sex 12 M 2 F 7. Age (1	n yrs. last birth	day) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	(Year) 7-53	9. Birthpl Count M, D	lace (State or Foreign try)
Varyand f show lad.at	10a. State 10b. County	4.	Oc. City, Town	or Location				10	0d. Inside City Limits
th with the Marylar 23s or 28e-f show set be notified at all Director	10e. Street and Number	eway A	ot b	10f. Zip Code	2/3	1	0g. Citizen of N		try?
hours after death variety or flame 23 If Examiner must d by Funeral	11. Marital Status  1 Never Merried Merried  3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1  Yes, Give Yeer or Detes:	or in U,S.	13. Was Decedent of Hif Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puerti Specify:	pecify Yes or No- o Rican, etc.)	14. Rad Blad	ce - America ck, White, e	etc.
ad within 72 ho ygiene. wer than "naturn 4, the Medical J Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)		16a. C	Decedent's Usual Occup Give kind of work done ifa. DO NOT use retire Mon C	during most of wor d)	king	16b. Kind of B	JA-	Justry
hould be file of Mental Hyg narked othe natic event, To Be C	17. Father's Name (First, Middle, L	WALKER			Hele	-	unTai.	n	
and 2 st safth and n 27 te n ser traus	19a. Informant's Name/Ralationsh Helen Four	MAIN		Mailing Address (Street 4 320 ご	ARCUA		A ITCO	Mel.	Code)
Pages 1 sent of H rnt: If lise ry or oth	20a. Method of Disposition  1 Burial 2 Cremation  4 Donetion 5 Other (Sp	3 □Removal from State	cemetery	Disposition (Name of crematory or other pla		522-22	20c. Location	COM	d
Departs Departs Imports any inju	21. Signature of Funeral Service L	icensee		22. Name end Addre	ess of Facility				1 18me
Physician	23a. Part . Enter the disease, or shock, or heart failure. List of	complications that caused the only one cause on each line.	e death. Do no						Approximate Interval Batween Onset and Death
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a	COTIC INT	OXICATION					
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hysician: The law requires that the death cartificate be his certificate has been signed by the attending physicial director, page 2 should be detached for use as the bur To Be Completed by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last  Part It. Other significant condition  25. Was case referred to medical examiner?  1 XYes 2 No  27. Manner of Death 1 Natural 5 Pending investig 2 Accident 3 Suicide 6 Could not detarmine 29a. Certifier 1 Certifying 29a. Certifier 1 Certifying 1	d.  Hospital: 1 Inpatient  28a. Date of Injury (Month, Day Ye Found: 23-99) 29e. Place of Injury building, etc. (5)	ato (or es e co ot resulting in l  ER/Outp ear) 29b. Ti in UNKNO - At home, lam Specify) HOME wy knowledge, amination end/	nsequence of):  nsequence of):  the underlying causa ghatient 3□ DOA Offine of 28c. Injury    Who   1□   1□   1□   1□   1□   1□   1□   1	26. Place of Dea ner: 4 □ Nursing H ry at rk?   Yes 2 ☒ No	24a. Was a performance of the pe	in autopsy med?  as 20 No hee)  ance 6 Oth ow injury occur  treet and Numit, State 432  MARYLAN	3 Prob  24b. We ave cor of to 1 Corer (Specify rred  Deer or Rura 20 CLAR	pebly 4 Unknow  ore autopsy findings sitable prior to mpletion of cause death?  Yes 2 No  I Route Number, EWAY

State Registrar MAY 2 7 1999 32. Registrat's Signature

B. fands

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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 19 /Medical 4a Facility Name (If not institution, give street and number) 4b, City, Town, or Location of De 4c. County of Death Examiner Hopkins saltimore HOSDITA, Johns N 8. Date of Birth (Month, Day, If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F Months Hours Min 215-30-Director Usual Residence of Deceden the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ahow 7 is marked other than "natural", or itema 23a or 28a-f ahor traumatic event, tra Medical Examinar maist be notified at 1 Yas 2 No NIA Director MD KANDALLSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? deeth with 11224 21133 KOAD USA ANWEL 12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. parmit. Pages 1 and 2 ahould be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if item 27 Is marked other than "natural", or hen eny Injury or other traumatic event, the Medical Exercises once. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 ☑ Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade comp 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) UNKNOWN 11 TH GRADE MKNOWN NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) +ORREST DUNNINGS MITH ROELEE 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SMITH 6558 ERI MO 21214 AUGHTER 10NEER 20b. Place of Disposition (Name of cometery, crematory or other plea 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 Ø Burial 2 ☐ Cremation 3 ☐ Removal from State 5-28-99 MEMORIAL KANDAUSTOWN 4 ☐ Donation 5 ☐ Other (Specify) MARK MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility GREENE FUNERAL SERVICE VAUGITN C. lese 5151 BALTO. PIKE, BALTO. NATL 23a. Part 1. Enter the chause, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart faulum. List only one cause on each line. Approximate Interval Between Onset and Deeth Physician /Medical Immediata Cause (Final disease or condition resulting in death) lears Examiner Due to (or as a consequence of): Examiner attending physicien end for use es the burlei-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflieted events resulting in death) Last Due to (or es a consequença of): P.O. Box 68760, Physician/Medical Due to (or as a consequence of): signed by the a Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Division of Vital Records. þ 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? has 2 No 1 Yes 1 Yas 2 No To the Hospital or Attanding Physician: "
within 24 hours after death.
To the Funeral Director: After this certifica completely filled in by the funeral director; p 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier

State Registrar

DHMH 16 Rev 6/95

29b. Signature and hith of offitties

Blankson

1999

31. Data filed (Month, Day,

MAY 27

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

600

North

Wolfe

32. Registrar's Signature

**ORIGINAL** 

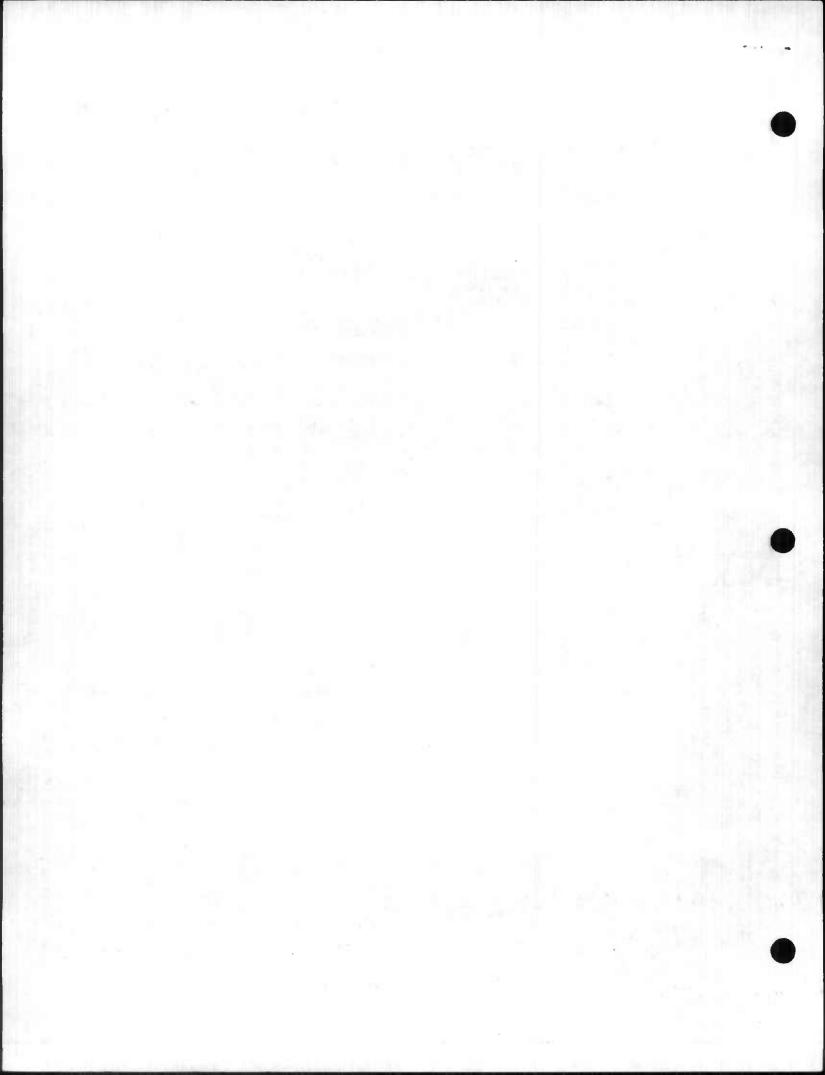
Street

29c. License number

Baltimore Maryland

29d. Date signed (Month, Day, Year)

21287-9106



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. IYEM#5 PER HSP. G771 5-20-99 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item 26 Per PHY FilmG770 4-22-99 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth **Physician** :23Am avier /Medical 4b City, Town, or Location of Death 4c. County of Death 4e Facility Neme (If not institution, giva street and number) Examiner Baltimore OSO114 HOPKINS Johns If Under 24 Hrs. 9. Birthplaca (State or Foreign 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 1√M 2□ F Mara UNKNOWN Director Usuel Residence of Decedent 10e, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f sho other traumstic avent, the Medical Examiner must be notified at Boltimos = 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Was Decedent Evar In U.S. Armed Forces? 1 \( \subseteq \text{ts} \) 2 PNo If Yes, Give Year or Datas: 5.4 death Funeral 14. Raca - American Indien, Bleck, Whita, atc. Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Mantel Status pemit. Pages 1 and 2 should be filled within 72 hours efter or Department of Health end Mentel Hyglene. Important: If Itam 27 Ia marked other than "natural", or iter 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working
, life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16h Kind of Business/Industry Eignfentery/Secondery (0-12) College (1-4or 5+) 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumema) Be 4 19e. Informent's Name/Reletionship (Type, Print) MARVIN 20b. Pleca of Disposition (Neme of comatery, cremetory or other place) 20c. Location -20e. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from State any Injury or 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Sumerei Service Licensee 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Pulmonary /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner Pulmonar attending physician end for use as the burial-trensit Sequentially list conditions, if eny, leeding to immediate causa. Entar Undarlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequanca of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 23b. Did tobacco use contribute to the cause of death? signed by t d be detect 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy performed? After this certificate 1 Yas 2 2 No 1 ☐ Yas 2 7 No or Attanding Physician: director, 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Hospital: XIX□ Inpatiant 2□ ER/Outpatient 3□ DOA 1 Yes 2 No Certification: To 28a. Dete of Injury (Month, Dey Year) funeral 27. Menner of Deeth 28d. Describe how injury occurred 28h Time of 28c. Injury et Work? 5 Pending 1 Neturel s efter deeth. 1 Yas 2 No Invastigation 2 Accidant 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 - Homicide Hospital 624 hours e Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and plece, end due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the cause(s) end menner stated. 29e. Certifier Medical (Check only one) within 2 To the 29d. Data signed (Month, Dey, Year) 29b. Signeture end title of cartifian 29c. License number UR MIKEE MO March 30, 1999 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Johns Hopkins Hospital-Pediatrics R. MCKEE, MD 32. Registrer's Signature 31. Dete filed (Month, Dey, Year) State MAY 2 7 1999 Registrar Sporker

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Division of Vital

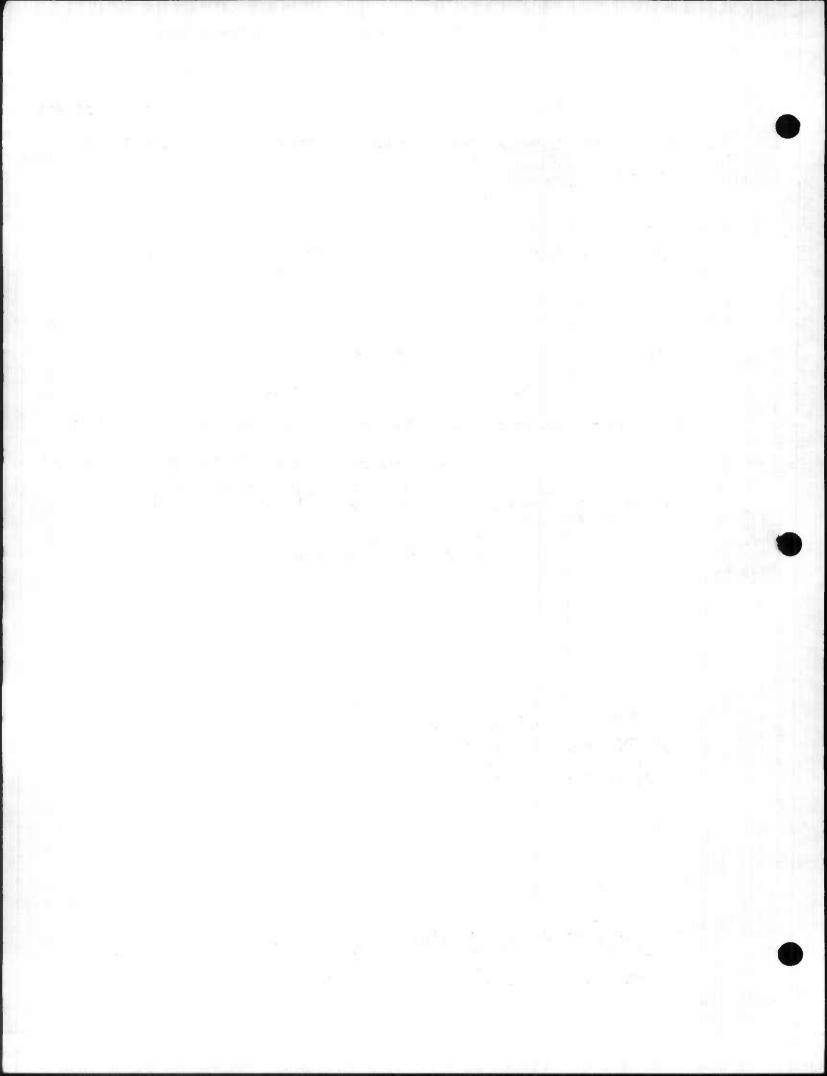
**DHMH 16 Rev 6/95** 

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year PHYLLIS YVONNE MAY WURZBACHER 1999 25 11:57AM /Medicai 4e. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE ff Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year)
April 20, 1934 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1□ M 20 F Director 213-32-9237 65 Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show Director 1 ☐ Yes 2 No Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 2504 Edgewood Avenue 21234 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes ≥ ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry pemit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "any Injury or other traumatic event, the Naging." Elementary/Secondary (0-12) College (1-4or 5+) 12 years Homemaker Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be Daniel Spurgeon Koller Margaret Kate Brown 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Streat end Number or Rurel Route Number, City or Town, State, Zip Code) Gilbert Perry Wurzbacher (Husband) 2504 Edgewood Ave. Parkville, Maryland 21234 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial Gardens 5-28-99 Timonium, Maryland 21. Sloneture of Funeral Servica Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. zecr 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Betw Onset and Death Immediate Ceuse (Final diseese or condition resulting in death) Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or as e consequenca of): Due to (or as e consequence of): signed by the at Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? eny-Body Variant 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24e. Was an autopsy performed? 24b. Were eutopsy findings available prior to completion of cause of deeth? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 No 2 1 Tes this 27. Menner of Death 1 ☑ Natural 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: A completely filled in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homleide Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29a. Certifier edicai 100 29b. Signature and title of certifie 29c. License number 29d. Date/signed (Month, Day, Year) new 30. Name and address of person who completed cause of greath (Item 23a) (Type, Print) TOWSON 12 ENILWOITH HERLINT. 17.0. (60 31. Date filed (Month, Day, Year) 32. Registrer's Signature Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

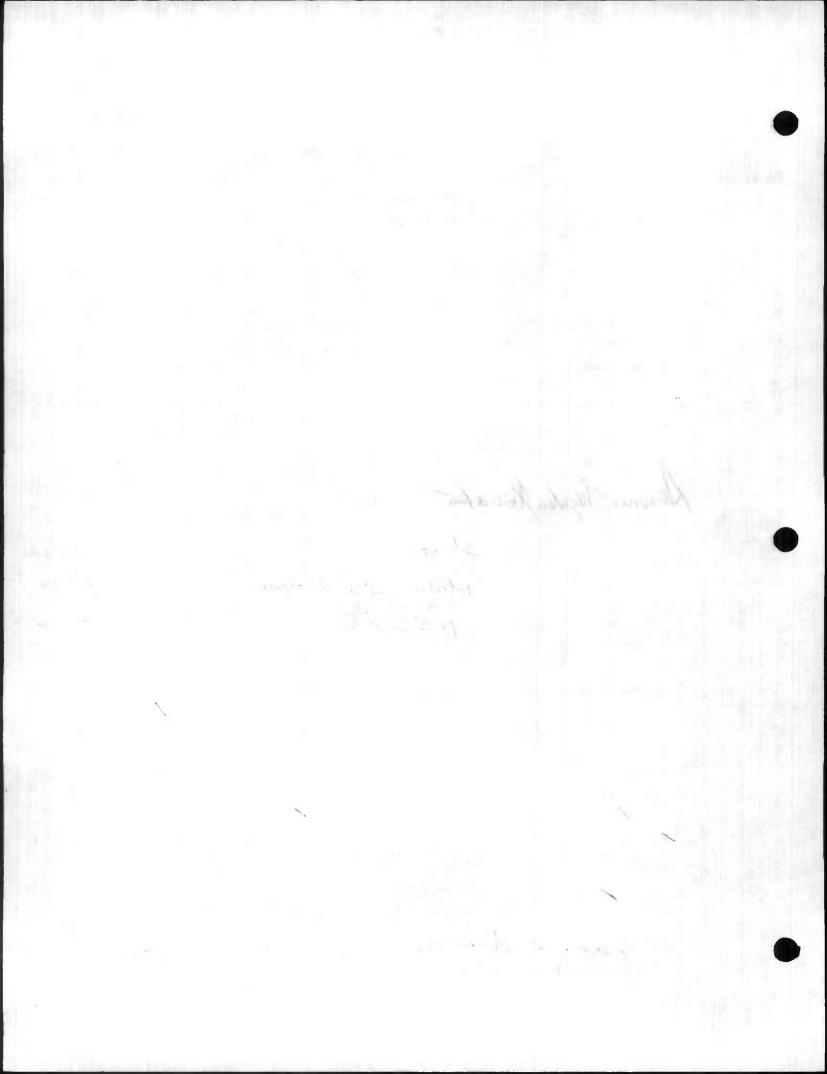


### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician May 25, 1999 JAMES MILLARD WHITE 10:40AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Roland Park PLace Baltimore If Under 1 Yaer | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
5 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1∏M 2□ F Yrs Director 216-20-9445 74 January 21, 1925 Usual Residence of Decedent the Meryland 10a State 10b. County 10c. City, Town or Location work 10d. Inside City Limits than "natural", or hame 23s or 28s-f show the Medical Examiner must be notified at Yes 2□No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filled within 72 hours effer deeth with it.
Department of Health and Mentel Hygiene.
Important: If frem 27 is marked other than "natural", or frems 23s or 3 eny injury or other traumatic event, the Medical Essents. 830 West 40th Street 21211 USA Funerei 11 Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ()(No Specify: 2 3 □ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Property Accountant Railroad 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) B Madeline Fontaine Millard Thomas White 2 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Wife 830 West 40th Street Baltimore, Maryland 21211 Pearl C White 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1XX\Burial 2 Cremetion 3 Removel from State 5/27/99 Baltimore, Maryland Parkwood Cemeterv 21. 36 ature of Funeral Service Licenses 22. Nema end Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart feiture. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner (or as a consequence of): Examiner The lew requires that the death certificate be executed physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yas 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed page 2 2 0 No 1 Yes 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) 1 Yes 2 No Other: Mursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation **Watural** deeth. 1 ☐ Yes 2 ☐ No 2 Accident after deeth Director: 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 6 ☐ Could not be within 24 hours after de To the Funeral Directo completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. ed ce 29a, Certifier ŝ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 5/26/ 99 30. Name and address of person with completed cause of death (Item 23a) (Type, Print) Gregory Walker MD 3333 N Calvert St Baltimore, Maryland 21218 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAY 27



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Day Month **Physician** JAMES WILSON 1999 10:462 /Medical 4e Fecility Neme (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8. Data of Birth (Month, Dey, Year) HOPKINS JOHNS S HOSPITAL 7. Aga (In yrs. lest birthday) BALLIMORE If Under 24 Hrs. 8 If Under 1 Year 5. Sociel Security Number 9. Birthplace (State or Foreign Country) 6. Sey 1 M 2 □ F **Funeral** Deys Hours 39 Months Min Yrs. Director Usual Residence of Decedent with the Marylend 10e. Stata 10b. County 10c. City Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No saltimore Directo 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 806 ierst 21213 SA 600 toel Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decadent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) Reca - American Indien, Bleck, Whita, atc. 11 Marital Status filed within 72 hours eftar 1 Yes 2 If Yes, Give 1 Never Merried 2 Married 2 No altimore, Maryland 21215-0020 1□ Yes 2□No Specify p 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) LIKN 16b. Kind of Business/Industry I Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) 84 .. Pages 1 and 2 should be filed w tment of Health end Mental Hygier tant: If item 27 is marked other ti jury or other trsumatic event, In other 1 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumama) Be Mayfell 2 ramez WILSON N1 54 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) 19e. informent's Name/Relationship (Type, Print) Mayfel 20b. Place of Disposition (Name of generally, cremetory or other place) Wisan- Mother 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State 5/249 permit. Page Department of Important: If any Injury or 4 ☐ Donetion 5 ☐ Other (Specify) O 22. Name and Address of Facility

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To the Funeral Director: After completely filled in by the funeral process. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and menner stated. 29a, Certifier edical (Check only one) 29d. Date signed (Month, Dev. Year) 29b. Signeture end title of certifier 29c. License number - H.D. 21,1999

State Registrar 31. Dete filed (Month, Dey, Year) MAY 2 7 1999

STUART M. LEVINE, M.D. 32, Registrer's Signature

GOO N. WOLFE ST.

RES-000

BALTIMORE, NO

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30. Neme end eddresa of person who completed cause of deeth (Item 23e) (Type, Print)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month **Physician** Dennis Eugene Wilson 1:30 AM May 26, 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore** 2414 Rockwell Ave **Baltimore** If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 10 M 20 F Months Hours 63 190-28-8410 Director Pennsylvania February 12, 1936 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No **Baltimore Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2414 Rockwell Ave. 21228 U.S.A. Funeral 11, Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Physics Lab Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Pages 1 and 2 should be nent of Health and Mental Wilbert Wilson Mae Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2414 Rockwell Ave. Baltimore, Maryland 21228 Mrs. Rose Wilson Wife altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 05/28/99 Clarksville, Maryland Columbia Memorial Park 4 Donation 5 Other (Specify) re of Funeral Service Licenses 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 MO0535 Part1. Enter the disease/or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 11 mos. lung cancer Examiner Examiner The lew requires that the death certificate be executed inding physicien and use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of) been signed by the a should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 2 No 1 Yes 2 No 1 Yes certificata Division of Vital or Attanding Physician: funeral director, 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To After this 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural 5 Pending investigation To the Hospital or Attandir within 24 hours after deeth. To the Funeral Director; A 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) filled in by 4 Homicide 1 Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) May 26, 1999

State Registrar

**DHMH 16 Rev 6/95** 

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D40850

goo CATON AVE BALTIMOR Md 21229

MD

d address of person who completed cause of death (Item 23a) (Type, Print)

OTTAVIANO

32. Registrar & Signature

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 Certificate of Death

Physici /Medi Exami

Funeral Director

permit. Pages 1 and 2 should be liled within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0020

Adolphu alle

Physician /Medical **Examiner** 

To the Hospital or Attending Physician: The law requires that the death cartificate be executed within 24 hours after death.

To the Funeral Director: After this cartificate has been signed by the attending physician and completaly filled in by the funeral director, page 2 should be detached for use as the burlat-transit Division of Vital Records, P.O. Box 68760,

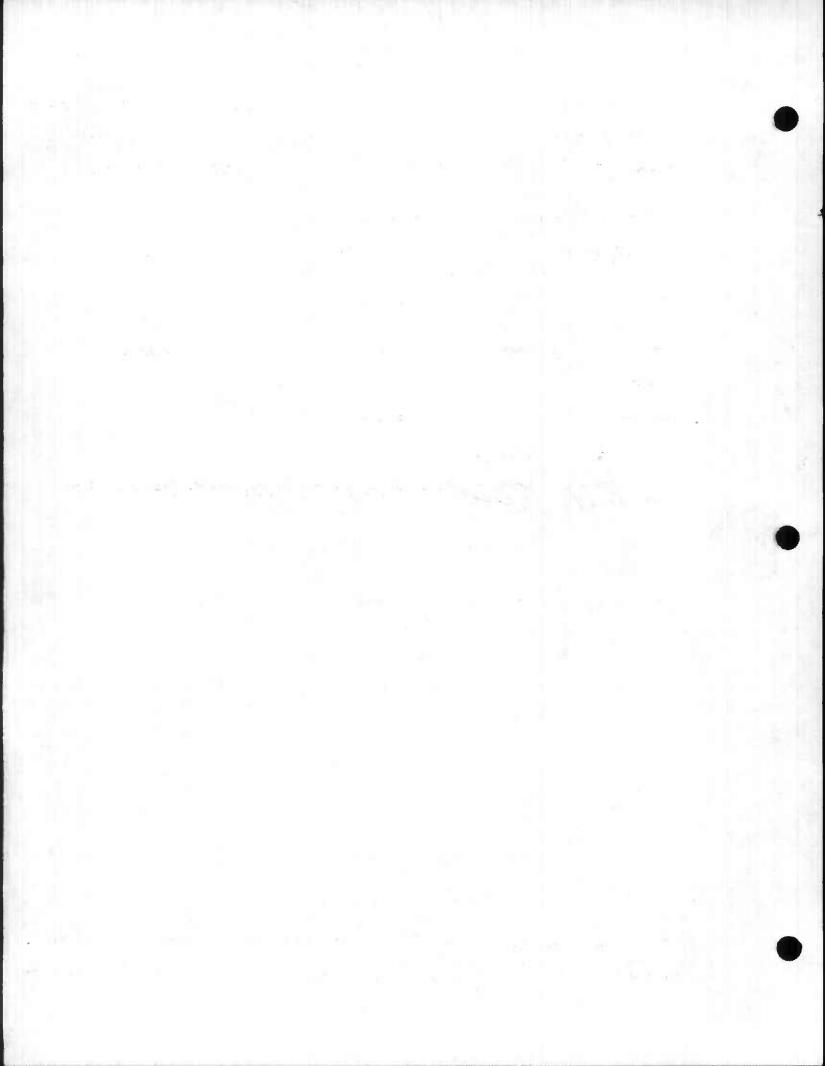
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Social Security Number     6. Si	ex □M 2 <b>1X</b> F	7. Age (In yr			If Under 1 Months	Year	if Under Hours	24 Hrs. Min.	8. Date of	Birth Dev. Ye	ear)	9. Birth	hplace (S	Stete or Foreig
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G. Sparks

32. Registrer's Signeture

31. Dete filed (Month Ray Y2") 8 1999

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month Year **Physician** Robert May 25 1999 J. Aycoth 7:40 am /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Franklin Square Hospital Rosedale Baltimore If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) 6. Date of Birth (Month, Day, Year) Birthpiaca (State or Foreign Country) **Funeral** Days Months MOM 20 F Yrs. 62 Director 216-30-5778 30 1936 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23s Funeral 328 Poplar Road 21221 12. Wes Decedent Ever In U,S. Armed Forces?

1 ☐ Yes 2 No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Merital Status Black, White, etc. 1 Never Married 2 Married natural', or altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuai Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Eiementery/Secondary (0-12) College (1-4or 5+) Electrician Beth Steel permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oths any Injury or other treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be 10 Allison Aycoth Mabel Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Margaret Aycoth/Wife 328 Poplar Road Baltimore MD. 21221 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 5/27/99 Metro Crematory Inc. Baltimore 21. Signature of Funeral Service Licenses 22. Name end Address of Facility Connelly Funeral Home Of Essex 0 300 Mace Ave. Baltimore MD. 712 23a. Part1. Enter the disease, or peripiications that caused the death. Do not ente shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Physician /Medical Immediate Ceuse (Final Myocardi disease or condition resulting in deeth) Examiner Examiner pue Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be execu 68760 Physician/Medical the th Due to (or as a consequence of) Box P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? been signed by should be detac 1 Yes 2 No 3 Probably 4 Unknown Records, À 24b. Were autopsy findings available prior to Completed 24a. Was en eutopsy performed? completion of cause of death? 2 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 8 Other (Specify) edicai Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Naturat 5 Pending investigation death. 1 Yes 2 No ours after death erel Director: A filled in by the f 2 Accident 3 Suicide 6 Could not be determined 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Cartifier completaly 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Nema and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State Registrar

MAY 2 8 1999

D. H. SHERBOURNE

31. Date flied (Month, Dey, Year)

32. Registrar's Signature

9/01

5d

BALTO

FRANKLIN

STAS ROYLAN

To the

**DHMH 16 Rev 6/95** 

State Registrar

edical

Dennis 31. Date filed (Month, Day, Year) MAY 2 8

4 Homicide

29b. Signeture end title of cartifier

Dennis

29e. Certifier

Chute, MD 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

O.C.M.E.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

MAY

29d. Date signed (Month, Day, Year)

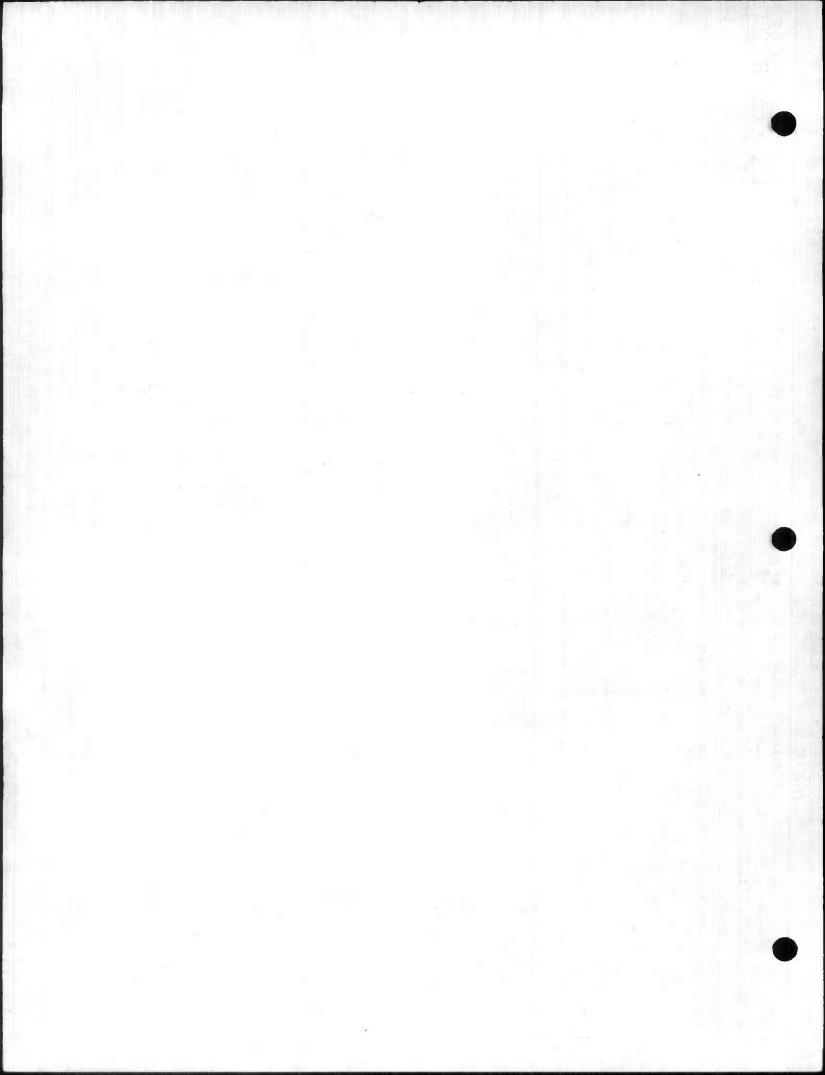
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1999

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28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

**ORIGINAL** 



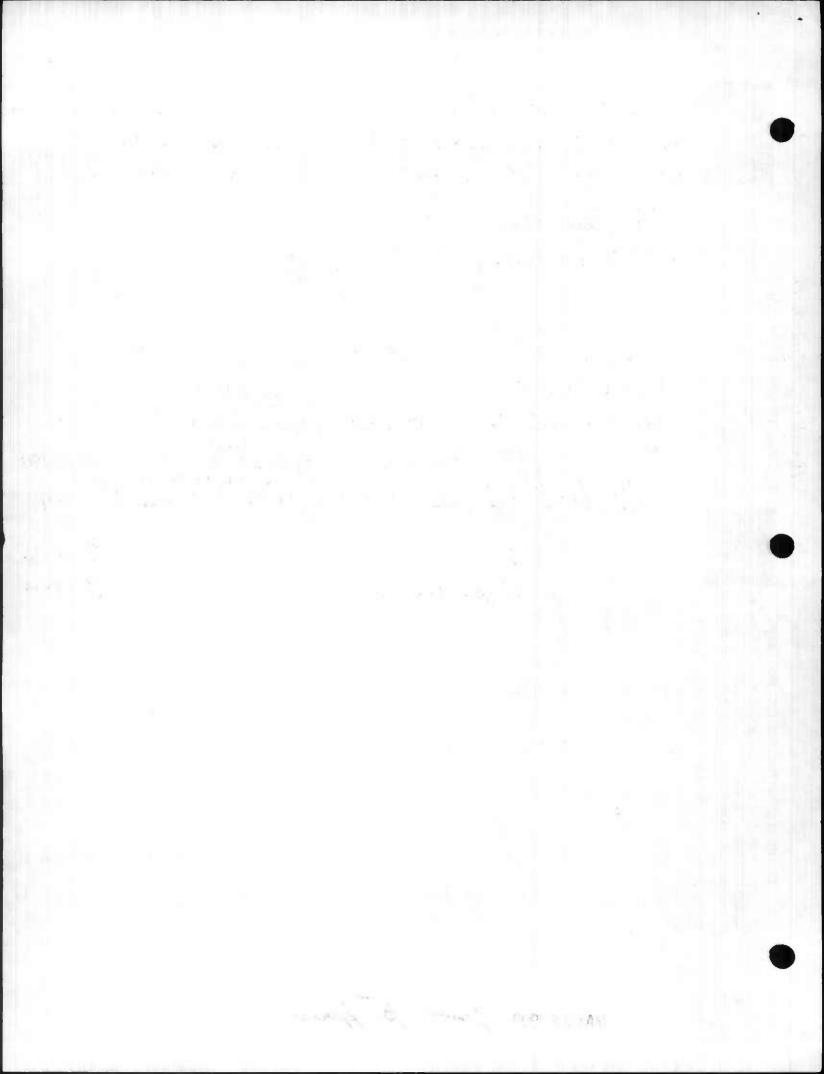
## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		Decedent's Name	/First Middle La		- Ivial yia		tificate of	Death		leg. No.	3 Time	of Death
Physicia	_	Mildred			m				May 23,		/ear	P.M.
/Medic Examin		4a Facility Name (If						4b. City, Town, or I	Location of Death	4c. County of		
		68 West I				- t t tt A	If Under 1 Year	Baltimor			imore	
Funeral Director		5. Social Security Nu 215–18–36 Usual Residence of	506	M 20xF		s. last birthday) 76	Months Days	Hours Min.	(Month, Day	, Year)	Birthplace (Stete Country) Maryland	or Foreign
with the Maryland a or 28a-f show the notified at	tor	10a. Stete Maryland	10b. County Baltimor	re		City, Town or Loc Ltimore	cation				10d. Inside	City Limits
10 th	Director	10e. Street and Num					10f. Zip Code			log. Citizen of Wh	et Country?	44
oath v	Funeral	68 West I	lingston	Park La		U.S. 13 V	21220	dispanic Origin? (S.	pecify Yes or No-	U.S.A.	American Indian,	
15-0020 172 hours after death with the Maryla "ratural", or liens 25s or 28s-f shot edical Examiner must be notified at	P	1 Never Marrie		Armed Fo 1  Yes If Yes, Giv Yeer or D	rces? 2 No		Yes, specify Cub	dispanic Origin? (S an, Mexican, Puert Specify:	o Rican, etc.)	Black,	White, etc. White	
Maryland 21215-0020 of 2 should be filed within 72 hours at th and Martial Hygiene. It's marked other than "natural", or treumelic event, the Medical Exami	Completed	(Special Elementery/Second	15. Decedent's Ed fy only highest gra idery (0-12)	ducation ide completed) College (1	-4or 5+)	(Give I	OO NOT use retire	during most of wor	king	16b. Kind of Busi		
d 2 Hygie Hygie ent, Ib		17. Father's Name (i	First, Middle, Last,	)		House	wire	18. Mother's Nan	ne (First, Middle,	OWN HOM  Maiden Sumeme		
ylan Wentsi wrked o	To Be	Frederick	John Sc	chuman				Carrie :	Elizabet	h Vogel		
		19e. Informant's New John Brow		***				Road, Ba				
Baltimore, semit. Pages 1 at Department of Hea mportant: if item: my injury or other attos.			osition Cramation 3  Othar (Specifier)		State		sition (Name of netory or other pla 1 Mem. (			20c. Location - C Baltimor	ity or Town, Stata e, Maryl	and
CB760, Care to executed the provided the pro	In/Medical Examiner	23a. P.M. Enter the control of the c	ditions, mediete lying njury		Due to	eth. Do not ente	107 Old If or the mode of dying the mode of dying the mode of the control of the	inski Fun Eastern A ng, such as cardiac Carcinov Primari	venue, E c or respiretory err	est, Ma	Approxim Intervel B Onset and	ata letween d Deeth
.O. BOX the deeth cert by the attending	Physician/M	Part II. Other signific	ant conditions o	ontributing to de	eath but not re	esulting in the un	iderlying cause gr	ven in Pert I.	23b. Did to	obacco use cont	ributs to the caus	e of death?
	by Phy	em	shy ser	na,	Pulm	nonan	emk	olum	101	/es 2□No :	Probably 4	Unknown
Division of Vital Records, P or Attending Physician: The law requires that after death.  Director: After this certificate has been signed but by the funeral director, page 2 should be determined.	Completed		0						24a. Was e perfor		24b. Wera sutops available prio completion o of death?	or to
r Vital Reversite to the vision of the vital results of the vision of th									1 🗆 Y	es 200 No	1 🗆 Yes 2	No
Vital F	<b>(1)</b>	25. Was case referre examiner?  1 Yas 2 1		Hospitel:	anationt Of		Ott DOA Ott	hor	ath (Check only or		10	
Division of Vita or Attending Physician: after death. Director: After this certific in by the funeral director,	itlon: To	27. Menner of Death  1 Neturel  2 Accident		28a. Date (Moni		28b. Time of Injury	28c. Inju Wo	ry at	loma 5 A Rasid 28d. Describe h	ow injury occurre		
Division of which the Hospital or Attending Phywithin 24 hours after death.  To the Funeral Director: After thi completely filled in by the funeral	Certification:	3 ☐ Suicida 4 ☐ Homicide	6 Could not be determined	286. Piece	of Injury - At ng, etc. (Spec		eet, fectory, office		28f. Location (S City or Tow		or Rural Route No	mber,
To the Hospital of within 24 hours at To the Funeral D completely filled to	edical	29a. Certifier (Check only one)	Certifying Ph	niner: On the ba	best of my kr asis of examinate stetled.	nowledge, death netion end/or inv	occurred at the ti estigation, in my	me, date and place opinion, deeth occu	, and due to the c rred at the time, o	eause(s) and mani lete end piece, sn	ner as stated. Id due to the ceuse	9(s)
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		30. Neme and eddre	ss of person who	completed caus	e of deeth (Ite	6,68	30, ho	spetal	drive	- MD -	2123	フ
Stat Registra		31. Dete filed (Mont)	MAY 281	999 32. R	ed strar's Sign	d.	Span	S.				

32. Registrar's Signeture

State Registrar 31. Dete filed (Month, Dey, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dale of Death 3. Time of Death Month 1998 Physician BrowNLEE 2:55 re MA 22 MAY /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner . AGNES HOSPITAL BALLIMONE If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 KF Months 62 Director 218-36-5451 37 01 M.D. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ahow 10d. Inside City Limits r than "naturel", or items 23s or 28s-f shorter Madical Examiner must be notified at 1 X Yes 2 No Director Baltimore MD NA 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 440 Cummings 21201 death Funeral 14. Race · American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status hours efter 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 TX Married altimore, Maryland 21215-0020 1□ Yes 2℃No Specify: Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Completed 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) House Keeping Home 6th grade na permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 ie marked other eny Injury or other traumade avent 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) 8 Mamie Johnson Robert Sawyer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 440 Cummings Ct., Baltimore Md Ernest Brownlee-Husband 20b. Place of Disposition (Neme of 20a. Method of Disposition Dete 20c. Location · City or Town, State cemetery, cremetory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Western Star Cemetery 5/29/99 Baltimore, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West Bla Warre 4300 Wabash AVe, Baltimore Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical PNIBUMONIA 100145 Examiner Due to (or as a consequence of): Examiner CANCER LUNG 1 YEAR burial-transit requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieled events resulting in death) Last pue Due to (or as a consequence of): physician s the burie P.O. Box 68760, DIABRIES HELLI'TUS 10-11-4157 Physician/Medical Due to (or as a consequence of): MINENA IRON DEFICIBNCY 14EAR Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? à 1 Yee 2 No 3 Probably 4 Unknown signed to Records, Š 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? FE 2 N No 1 Yes 2 No 1 Yes Vital BROWN 8 25. Was case referred to medical 26. Place of Death (Check only one) Hospitat: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA ot this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Atter Division Attending 5 Pending investigation 1 Naturat death. 1 Yes 2 No 2 Accident after death 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours edicai Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completaly (Check only within 24 h onel 29b. Signalure and title of certifier 29c. License number 29d. Dale signed (Month, Day, Year) M.D P12592 MA7 22 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) SOO CATON AVENUE BALLIMORE, MD KAWALEC MAKSY MY LL'AN 31. Dale filed (Month, Day, Year) 32. Registrar's Signature State

**ORIGINAL** 

DHMH 16 Rev 6/95

Registrar

MAY 28 1999

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey Year **Physician** Albert P. Biancucci 4b. City, Town, or Location of Death 1999 26 0705 /Medical 4a Facility Name (If not institution, give street end number) 4c. County of Deeth Examiner St. Agnes Hospital Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dev. Year) Birthpiece (State or Foreign Country) **Funeral** 1₩ 2□ F Months Deys Yrs. 217-03-7400 85 Director Italy Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10e State 10b. County 10d. Inside City Limits 7 is marked other than "naturel", or itema 23a or 28a-f sho treumatic event, the Modical Experient must be notified at 1 Ves 2 No MD N/A Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3300 Benson Ave., Apt. 105 DePaul House 21227 USA death Funeral 12. Wes Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2√ No If Yes, Give Year or Dates; 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indian Bleck, White, etc. filed within 72 hours after 1 ☐ Never Merried 2 ☑ Married Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grede completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 6 Bethlehem Steel Master Welder 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be filt ment of Health and Mental Hy ant: If Item 27 is marked oth lury or other treumstic event Be Guiseppe Biancucci Maria Agostinelli 10 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 21227 19a. Informent's Name/Reletionship (Type, Print) Sarah J. Biancucci - wife 3300 Benson Ave., Apt. 105, DePaul House, Balto., Md Baltimore, 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 5/31/99 1 Burial 2 Cremation 3 Removal from Stete 4 Donetion 5 Other (Specify) permit. Page Department o Important: If any Injury or Parkwood Cemetery Baltimore, Md. 22. Name end Address of Facility 21. Signeture of Funeral Service Licons Gary L. Kaufman Funeral Home @ Meadowridge MP. Inc. 7250 Washington Blvd., Elkridge, Md. of enter the mode of dying, such as cardiec or respiratory errest, 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter shock, or heart failure. List only one cause on each line. Intervel Between Onset and Death **Physician** several days /Medical Immediate Cause (Fine) e. Acute respiratory distress syndrome disease or condition resulting in death) **Examiner** 1-2 weeks Due to (or as a consequence of): Examiner 2 weeks Staphylococcal pneumonia physician and the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): The law requires that the death certificate be exec NAME: UMBERTO BIANCUCCI Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of): 88 esn signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Pulmonary asbestosis þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en eutopsy Myocardial infarction (remote) page 2 1 Yes 2 No 1 Yes 2 No certificate Hospital or Attending Physicien: director. 25. Wes case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 inpatient 2 2 ER/Outpetient 3 DOA this funeral 28a. Date of injury (Month, Dey Year) 28c. Injury at Work? 27. Menner of Death 28b. Time of 28d. Describe how Injury occurred Certification: After 1 Natural 5 Pending investigation 24 hours after death.

Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) completely filled in by 4 Homlcide 29a. Certifier (Check only one) 1🗹 Cartifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) end manner as stated. Medical 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) end menner stated. within 2 To the ŝ 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number D48054 May 26, 1999

21229

St. Agnes HealthCare - 900 Caton Avenue-Baltimore, Maryland

State Registrar

**DHMH 16 Rev 6/95** 

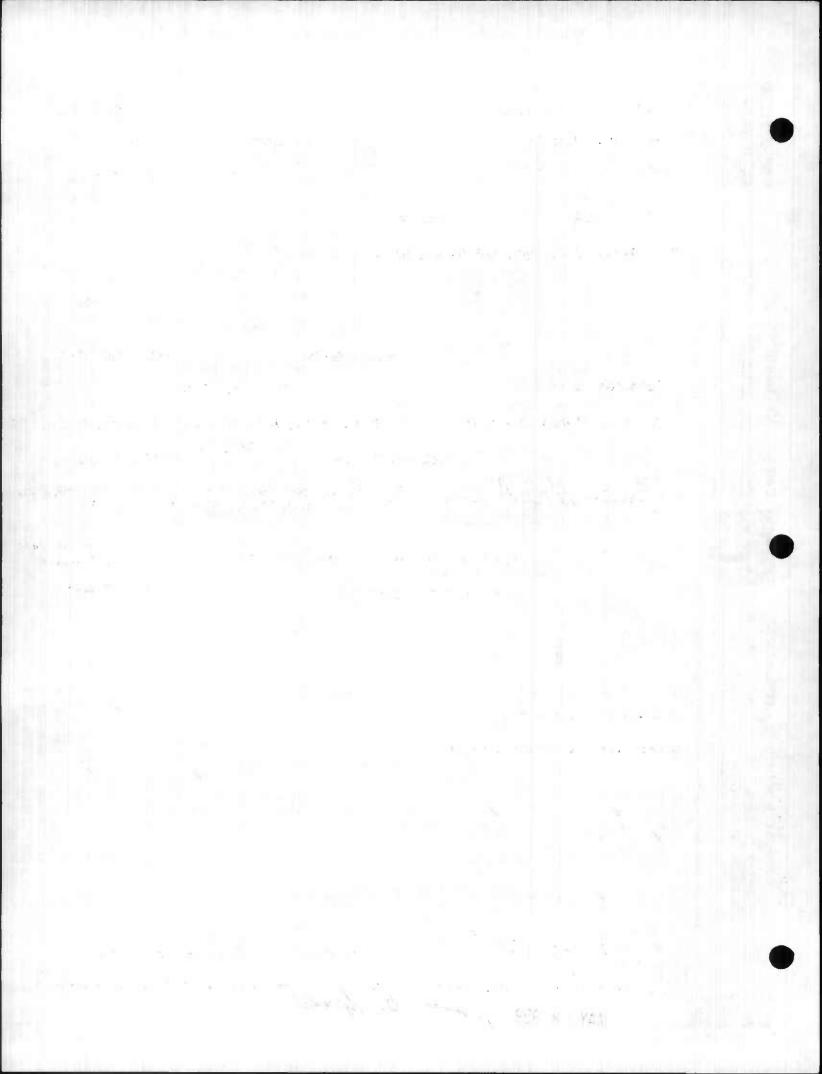
30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signeture

Dr. J. Ross Slemmer -

MAY 2 8 1999

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 03:55 Helen C. Brown /Medical of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location **Examiner** 21 11 more MITPMOUL aln If Under 24 Hrs. Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Days Months Min. 1 M 2 F Hours 216-32-0166 87 18, Director July 1911 Florida Usual Residence of Decedent 10b. County 10c. City, Town or Location r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. tnside City Limits 1 Yes 2 No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3320 Benson Avenue U.S.A. Funeral 21227 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 2 No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: P white 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygiene Important: If frem 27 is marked other that eny injury or other traumatic event, trail bhose. unknown unknown Sales Manager Industries for the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Charles Lark Salter Sophia Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Catherine Sattler/sister 701 65th Ave., South, St. Petersburg, FL 33705 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, State 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 ID Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licansee 22. Name and Address of Facility the Ronald 9 Made State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201 Director 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner quence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last ena Physician/Medical Due to (or as a consequence of) Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? á 1 Yes 2 No 3 Probably 4 Unknown signed b þ hrombosis 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy wes 1 ☐ Yes 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 27. Manner of Death 26a. Dete of tnjury (Month, Day Year) 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 TYes 2 □ No hours after death, 2 Accident 6 Could not be determined 3 Suicide within 24 hours after de To the Funeral Directo completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide n 24 hou. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier ş 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Neme and address of person who comp

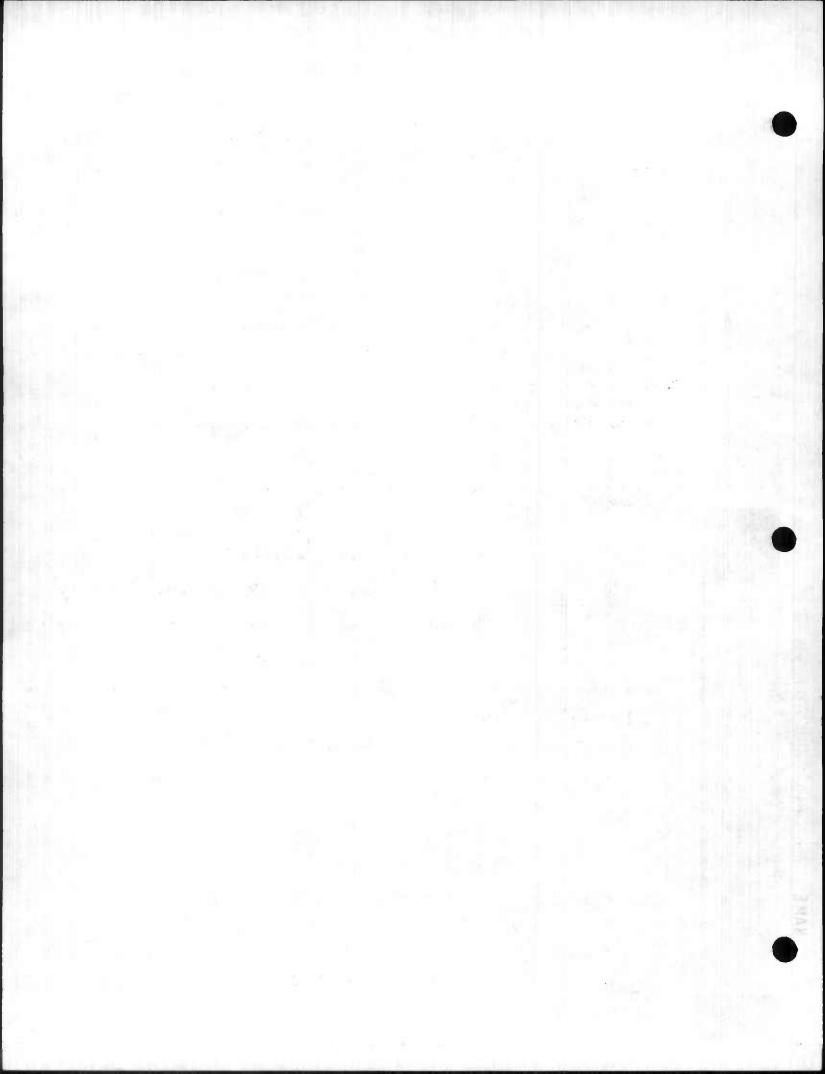
MAY 2 8 1999

31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

ered cause of death (Item 23a) (Type, Print)

32. Registrar's Signature



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Sarah V. Breiling 1999 9:10 pm May 18 4e. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Friends Nursing Home Sandy Spring Montgomery If Under 24 Hrs. Hours Min. 5. Social Security Number If Under 1 May 23, 19 6. Sex 7. Age (In yrs. last birthdey) 9. Birthplace (State or Foreign Country) Days 1□M 20 F Yrs 300-10-8294 Arkansas Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Montgomery Sandy Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 17401 Norwood Road 20806 U.S.A. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: white 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own home 17. Father's Neme (First, Middle, Lest) 18. Mother's Neme (First, Middle, Meiden Surname) James W. Penick Della Elizabeth Trimble 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 2213 Osborn Drive, Silver Spring, MD Jim Breiling/son 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☑ Donetion & Other (Specify) 21. Signature of Funeral Service Licensee 22. Neme end Address of Fecility Ronald S State Anatomy Board, 655 W. Baltimore Street Marie well Baltimore, MD 21201 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart fellure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Immediate Cause (Final diseese or condition resulting in deeth) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): 23b. Dtd tobacco use contribute to the cause of death? 3 Probably 4 Unknown

Physician /Medical Examiner

signed by the attending physician and d be detached for use as the burial-transit

peen

certificate has

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Certification:

Medical

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics

filled in by the funeral

The law requires that the death cartificate be executed

Division of Vital Records, P.O. Box 68760

**Physician** 

/Medical

**Examiner** 

10e. Stete

Directo

Funerai

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important if Item 27 is marked other than "natural" ~-\*\* any Injury or other traumatic everal any Injury or other traumatic everal any injury or other traumatic everal and the property of the p

Examiner Physician/Medical Š Completed Be

examiner'

27 Menner of Deeth

2 Accident 3 Sulcide

4 ☐ Homlcide

Thomas Ef Oddley 31. Dete filed (Month, Dev. Year) MAY 2 8 1999

29e. Certifier

Netural

1 Yes

Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 25. Wes case referred to medical 28. Place of Deeth (Check only one)

24e. Wes en eutopsy

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

-	to the state of th	
	5 Residence	6 ☐Other (Specia
4	D 2	

1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Yes

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end menner stated. (Check only 29b, Signatura and talg of certifier

5 Pending investigation

6 Could not be determined

29c. License number

29d. Dete signed (Month, Day, Year)

30. Name and address of parson who completed cause of death (flem 23a) (Type, Print)

State Registrar

17904 RGOKGIA 32. Registrer's Signeture

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth 2. Date of Death Month Physician Doris F. Burns May 21, 1999 9:45 AM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Alice Manor Nursing Center Baltimore, H Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 200F Yrs. 218-07-1244 81 Director Nov. 25, 1917 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 ¥ Yes 2 □ No Maryland Directo N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours effer death with Hyglene. Sther than "netural", or frems 23s or end, fre Medical Exercitive must be a Alice Manor Nursing Home 2095 Rockrose Avenue Funeral 21211 USA 12. Wes Decedent Ever in U,S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Merital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: Specify: White P XI Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mentel Physiery important: if them 27 ie marked other the eny injury or other treumatic event, the Dates. Homemaker Own 12 Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George P. Henze Sarah F. Johnson 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julia Thorwegen 7047 Bissonnet No. 81 Houston, Texas 77074 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete Dete 1 Burial 2 Cremation 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Park Cemetery 5/28/99 Woodlawn, Maryland 21. Signature of Funeral Service Vicense 22. Neme and Address of Fecility Burgee-Henss-Seitz Funeral Home, Inc 21211 23a. Part! Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical tmmediate Cause (Finel Candro my opath disease or condition resulting in death) Examiner Examiner disease Corona physician and the burlai-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or es e consequence of): brabetes Box 68760 Physician/Medical Due to (or es a consequence of) 8 mon fittena 980 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown ine 2 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed s cartificate hes b 1 🗆 Yes 2 100 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this cardifica completely filled in by the funeral director; I 25. Was case referred to medical examiner? 8 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 DNatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 281. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edicai 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D31464 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Entano St Smite 308,

State Registrar DHMH 16 Rev 6/95

MAY 28 1999

31. Date filed (Month, Day, Year)

H731tm1

32. Registrar's Signeture

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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 1999 6:18am 23 may CURTIS GLENN BERRY

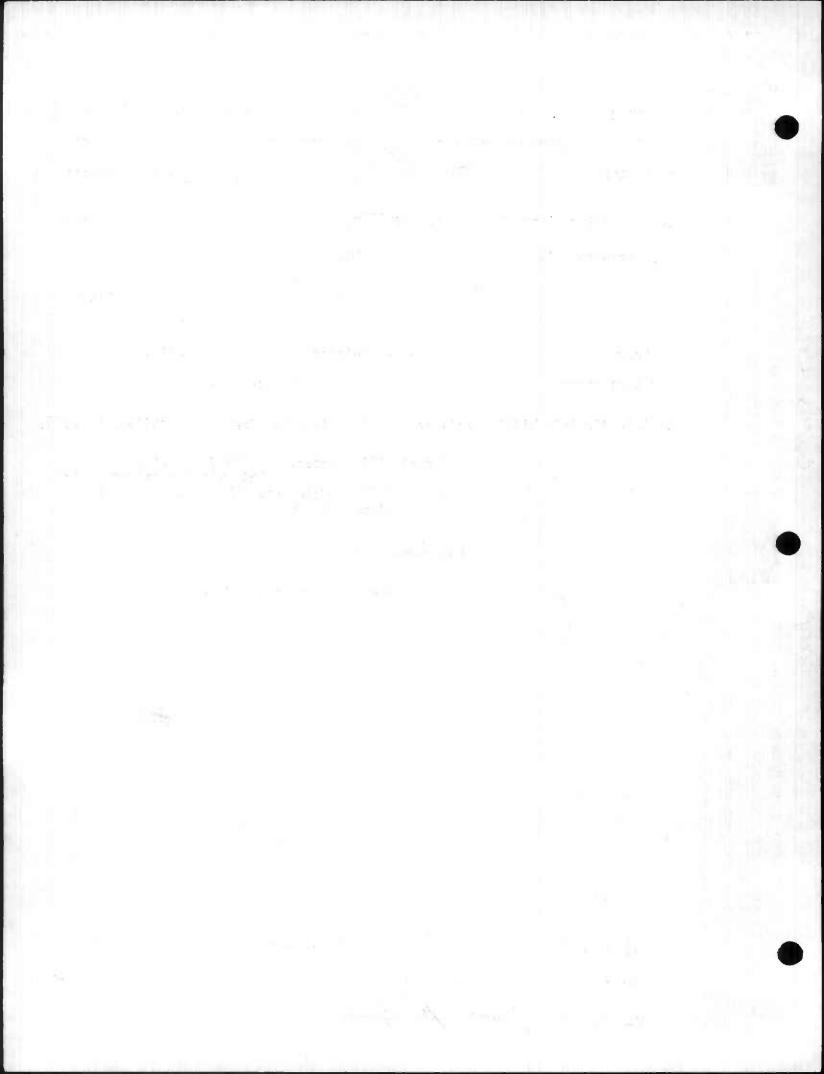
4e. Facility Name (If not Institution, give street end /Medical 4b. Clty, Town, or Location of Deeth 4c. County of Death Examiner Lanham Community Doctors Prince Georges Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplace (Stete or Foreign Country) **Funeral** 1□M 2□F 83 Yrs **Director** 579-16-5421 Jan. 02, 1916 Roundhill, VA Usual Residence of Decedent r 28a-f show 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits YYes 2 No Forestville, MD Director Prince George's MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23s or traumatic event, the Medical Examiner must be r Pike 20747 USA 7420 Marlboro Funeral 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, permit. Pages 1 and 2 should be filled within 72 hours after d Department of Heelih end Mental Hygiene. Important: If item 27 is marked other than "natural". Any Injury or other traumatic events. Black, White, etc. 1 ☐ Yes 2 ☐ YNo If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: by Specify: Black 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) House Painter Private Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Sobert Berry Luttie Webster 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) #209 Hyattsville, MD 20783 Lavinia Virginia Williams/sister 6305 Riggs Rd 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete 1 X Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill Cemetery 5/28/99 Clinton, MD 22. Name and Address of Fecility Latney's Funeral Home, 21. Signature of Funerel Service Licensee 28 NW Wash 3831 Georgia Ave. DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or freen feilure. List only one cause on each line. **Physician** 1 day immediate Cause (Final disease or condition resulting in death) Pneumonia /Medical Examiner Due to (or es e consequença of): Examiner cerebrovascular Accident physician and the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Physician/Medical Due to (or as e consequenca of) ettending p Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? Division of Vital Records, P.O. signed by t 1 Yas 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 s 2 10 No 1 ☐ Yes 1 Tyes 2 No Hospital or Attending Physician: 24 hours after death.
 Funeral Director: After this carific. funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Certification: To Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 LN6 1 III Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 5 Pendina 1 TYes 2 TNo Investigation 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) in by 4 Homicide filled 29a, Certifier 1[Deartifying Physicien: To the best of my knowledge, death occurred et the time, date and placa, and due to the cause(s) and manner as stated Medicai To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end placa, and due to the cause(s) and manner stated. 29b. Signeture end title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 039550 5-23-99 30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print) 4850 Forbes Blud. Lanham, Wd. 20706 Hallar, Jr. m.O. George

DHMH 16 Ray 6/95

State Registrar 31. Date filed (Month, Dey, Year)

MAY 2 8 1999

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔾 🔾 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death 25TH Month **Physician** SHTYOS BLAS. 1999 5:40 Am MAY /Medical 4e. Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** CENTER RAMPALLSTOWN HOSPITAL BALTIMORE: NORTHWEST 7. Age (In yrs. last birthdey) If Under 1 Yeer If Under 24 Hrs.

Months Deys Hours Min. 8. Dete of Birth
(Month, Dey, Year)
JUNE 20,1919 5. Social Security Number 9. Birthpiece (State or Foreign **Funeral** 1□M XTF NEW YORK Yrs Director 102-05-6665 Usuel Residence of Decedent 10e State 10h Counts 10c. City, Town or Location 10d. inside City Limits r 28a-f show 1 Tyes X No Director MD BALTIMORE BALTIMORE 10f. Zip Code 21208 10e. Street end Number 10g. Citizen of What Country? item 27 is marked other than "naturel", or items 23a or other traumatic event, the Medical Examiner must be a 7920 SCOTTS LEVEL RD. USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, atc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 1 ☐ Yes 🏋 No Specify: Specify WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent'e Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) 12 CROSSING GUARD BALTO. CITY SCHOOLS 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be FRANKLIN ANNE **BROOKS** JACK 19a. Informent's Name/Raiationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 301 PLEASANT RIDGE DR., APT. T-3 OWINGS MILLS, #MD permit. Pages 1 and 2 Department of Haalth as Important: If Item 27 is any Injury or other trau DR. SANFORD BLAS (SON) 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Buriei 2 □ Cremetion 3 □ Removel from Stete 5/26/99 4 ☐ Donetlon 5 ☐ Other (Specify) ANSHE EMUNAH BALTIMORE, MD 21. Signature dijunerel Service Licensee 22. Name and Address of Facility
SOL LEVINSON & BROS., INC. Potre 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Onset end Deeth **Physiclan** /Medical immediate Cause (Final PHEUMONIA. diseese or condition resulting in deeth) Examiner Due to (or es a consequenca of): Examiner physician and s tha burial-transit Sequentially list conditions, if any, laeding to immediate cause. Enter Underlying Couse (Disease or Injury that initiated evants resulting in deeth) Last Due to (or es a consequence of): Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown OBSTRUCTIVE PULMONARY DISEASE. 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed 1 Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Wes casa raferred to medical exeminer? Be 28. Place of Deeth (Check only one) Hospitel: 1 ♣ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 1 Neturei 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, ferm, street, factory, office building, atc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicida edicai 1 Cortifying Phyeician: To the best of my knowledga, daath occurred et the time, deta and place, and dua to the causa(s) and mannar as stated.
2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) end manner steted. 29a. Certifier 29b. Signeture and the of certify MAISISPHP 29c. License number 29d. Date signed (Month, Dey, Year) House and MAY D 42723

State Registrar

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72 hours after

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Baltimore, Maryland 21215-0020

Box 68760,

P.O.

Records,

Division of Vital

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31. Date filed (Month, Day, Year)

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32. Registrer's Signeture

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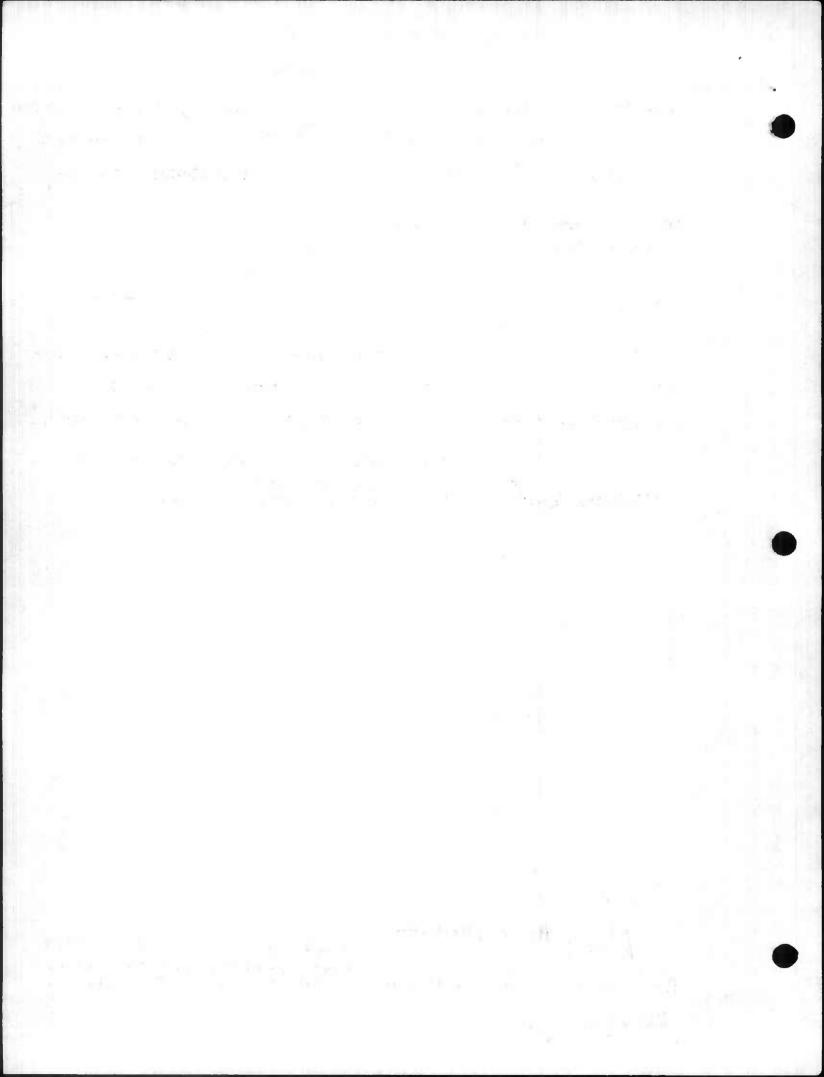
30. Name end address of person who completed cause of daeth (itam 23a) (Type, Print)

3745 FOXFORD

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State of Maryland / Department of Health and Mental Hygiene

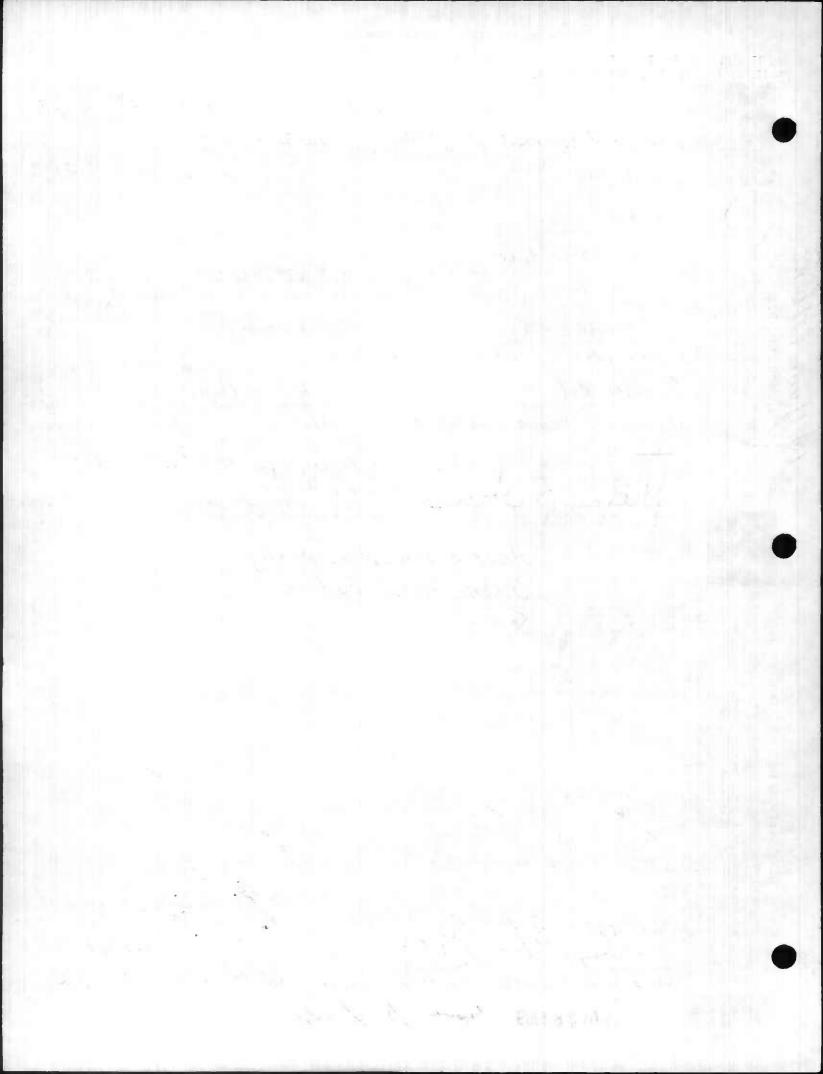
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Beulah A. 5:00 am. May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 830 Suburbian Road Reisterstown Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Soclei Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Days Virginia 216-36-3770 96 Yrs. Director July 1, 1902 Usuei Residence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director Baltimore Maryland Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 830 Suburbian Road 21136 USA death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 ☐ No if Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Bleck, White, etc. 11. Marital Status 72 hours after 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Depertment of Health and Mentel hygiene. Important: If Item 27 is marked other than "nany Injury or other traumatic avent, the Heal Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Homemaking 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Sumame) Be Willie Snyder Lula Swisher 19a. informant's Name/Relationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Miss Georgene Batz 830 Suburbian Rd., Reisterstown, Md. 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cemetary, cremetory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State 5/29/99 Finksburg, Md. 21048 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Mem. Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel 11605 Reisterstown Rd., Owings Mills, Md. 21117 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on each lina. Approximate Interval Between Onset and Death **Physician** /Medical . pypertensies arleves clarate heart discon Immediata Cause (Final disease or condition resulting in death) Examiner Examiner buriel-transit end Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lasf Dua to (or as a consequence of): physician s the buriel P.O. Box 68760 Physician/Medical Due to (or as a consequence of): Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, by 2 should t 24b. Were autopsy findings evailable prior to complation of cause of death? Completed 24a. Was an autopsy periormed? has 1 Yes 2 No 1 Yes 2 No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No To 28a. Date of injury (Month, Day Year) funeral 28c. fnjury at Work? 27. Manner of Death Certification: 28b. Time of 28d. Describe how Injury occurred 1 Naturai 5 Panding 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, offica building, etc. (Specify) in by 4 Homicide 29a, Certifier 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. Medical 2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Jaurena Kallager, NO DO1786 30. Name and address of person who complated causa of death (item 23a) (Typa, Print) 31. Date filed (Month, Day, Year) 716 Maider Choice have Lauro 32. Registrade Signature State Registrar

**DHMH 16 Ray 6/95** 

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED ITEM #12 PER FH G780 2/7/2000 Certificate of Death ITEMS: #2CA PER F.H. G771 5-28-99 WR 1. Decedent's Neme (First, Middle, Last) 2 Date of Death 2 9ey **Physician** 340 Colbert 124 · /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Neme (If not institution, give street and number) Examiner ary/and Baltimore 6. Sex 1 M 2□ F If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) **Funeral** Deys 216-18-0984 Director Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Ves 2 No NA Director treumetic event, the Medical Examiner must be notified 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 200 Street U,5-A Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. 1 X Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married 1 Yes 2 No Black by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Curik Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) haborer NA 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumeme) Be Colbert, Sr 10 Chartes 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 2/060 mportant: If them 27 is Colbert -- Brother 354 1stren ant of Health 40 7/en Burnie enue 20e. Method of Disposition Plece of Disposition (Name of cemptery, cremetory or other plece) 20c. Location - City or Town, Stete Date Pages 11X Burial 2XX Cremetion 3 Removel from Stete 4 Donetion 5 Dother (Specify) ra of Funeral Service Licensee 22. Name and Address of Fecility arch F. A. West grenne Balto, old 2120 Wabash 23e. P. rt1. Enter the Useese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, at pck, or heart letture. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** Immediete Cause (Finet diseese or condition resulting in deeth) /Medical Examiner Examiner attanding physician and for usa as the bunal-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es a consequença of) Box 68760. Physician/Medical Due to (or es e consequence of): P.O. Pert tt. Other signiffcant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records. þ 24b. Were autopsy findings evellable prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? cartificata has 2 3 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Dete of fnjury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. fnjury et Work? Certification: 5 Pending investigation 1 Maturel al or Attending s after death. I Director: Aft 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pieca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 - Homicide To the Hospital within 24 hours a To the Funeral E Hospital 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, and due to the cause(s) end manner as steted. edical (Check only one) niner: On the basis of examination and/or investigation, in my opinion, death occurred at the filme, date and placa, and due to the cause(s) 29b. Signature and fig. certifie 29c. License number 29d. Date signed (Month, Day, Year) 13 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) land General Hospital SCHWARTZ 31. Dete filed (Month, Day, Yeer) 32. Registrar's Signeture State Gener MAY 28 1999 Registrar **DHMH 16 Rev 6/95** 



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Tima of Death 1. Decedent's Nama (First, Middle, Last) **Physician** VIRGINIA 7:47AM Ma /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Baltimore 8. Data of Birth (Month, Dey, Year) Joseph If Undar 1 Yaar 9. Birthpiaca (Steta or Fgreign 6. Sax 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Days Min Months Hours 219-28-6348 Usuei Rasidence of Dacedant 1□M 2♥F 1 Yrs Director 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other treumstic event, the Medical Examiner must be notified at 1 Yas 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 5 23a 260 permit. Pages 1 and 2 should be filed within 72 hours effer death Department of Health end Mentel Hygiene. Important: If item 27 ie marked other than "natural", or items 23. Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Spacify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian 11. Maritai Status Biack, Whita, atc. 1 ☐ Yas 2 No If Yas, Giva Yaar or Detas: 1 Nevar Marriad 2 Married 1□Yas 2♥No Baltimore, Maryland 21215-0020 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Elamantary/Secondary (0-12) Collega (1-4or 5+) nomema 12 18. Mothar's Nama (First, Middle, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Be Illiam 4 nna 19b. Meiling Address (Streat and Number or Rural Route Number, City or Town, State, 19e. Informent's Name/Reletionship (Type, Print) Howard 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) Data City or Town, State May 27 1 ☐ Buriai 2 ☐ Cramation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Ramoval from Stata any injury or vans Funeral Chapel-22. Nama and Addrass of Facility 21. Signature of Edneral Service License Evans Panti. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate intarval Batwaan Onsat and Death Physician several · ruptured thoraco - abdominal aneurysm /Medical Immadiate Causa (Final disaesa or condition rasulting in daath) hours Examiner Strtal of ruptured aneurysm Hempted Examiner physician end the buriel-transit Sequantielly list conditions, if any, laading to immadiate causa. Entar Underlying Ceusa (Diseesa or injury that initiated avants resulting in death) Lest that the death certificate be exec Division of Vital Records, P.O. Box 68760 Physician/Medical Dua to (or as a consaquance of). 60 use signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 □ Probably 4 ☑ Unknown ρ 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 s certificate hes 2 X No Hospital or Attending Physician: 25. Was casa rafarrad to medical axaminar? Be 26. Plece of Death (Chack only ona) Hospital: 1 Ves 25 No Other: 4 Nursing Homa 5 Rasidanca 8 Othar (Specify) 2 1 Inpatient 3□ DOA 2 ER/Outpatient After this funerel 27. Mannar of Death 28e. Date of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 Yas 2 No 24 hours after deeth.

Funeral Director: A Invastigation 2 Accidant 8 Could not be determined 3 Suicida 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) Placa of Injury - At homa, farm, straat, factory, offica building, etc. (Specify) completely filled in by 4 Homicida 150 Certifying Physician: To the best of my knowledge, daath occurred at tha tima, dete end place, end due to the cause(s) and mennar as stated.

2 Medical Examiner: On the best of axamination end/or investigetion, in my opinion, deeth occurred at the tima, data and place, and due to the cause(s) and mannar stated. Medical 29a. Certifier within 2 To the I \$ 29d. Data signed (Month, Day, Year) 29b. Signature and title 29c. Licansa number 0 lored causa of deeth (Item 23e) (Type, Print)

MHOS

State Registrar

MAY 2.8 1999 DHMH 16 Rev 6/95

31. Data filed (Mohth, Day, Year)

MAY 2.8 1999

Signature B. Spork

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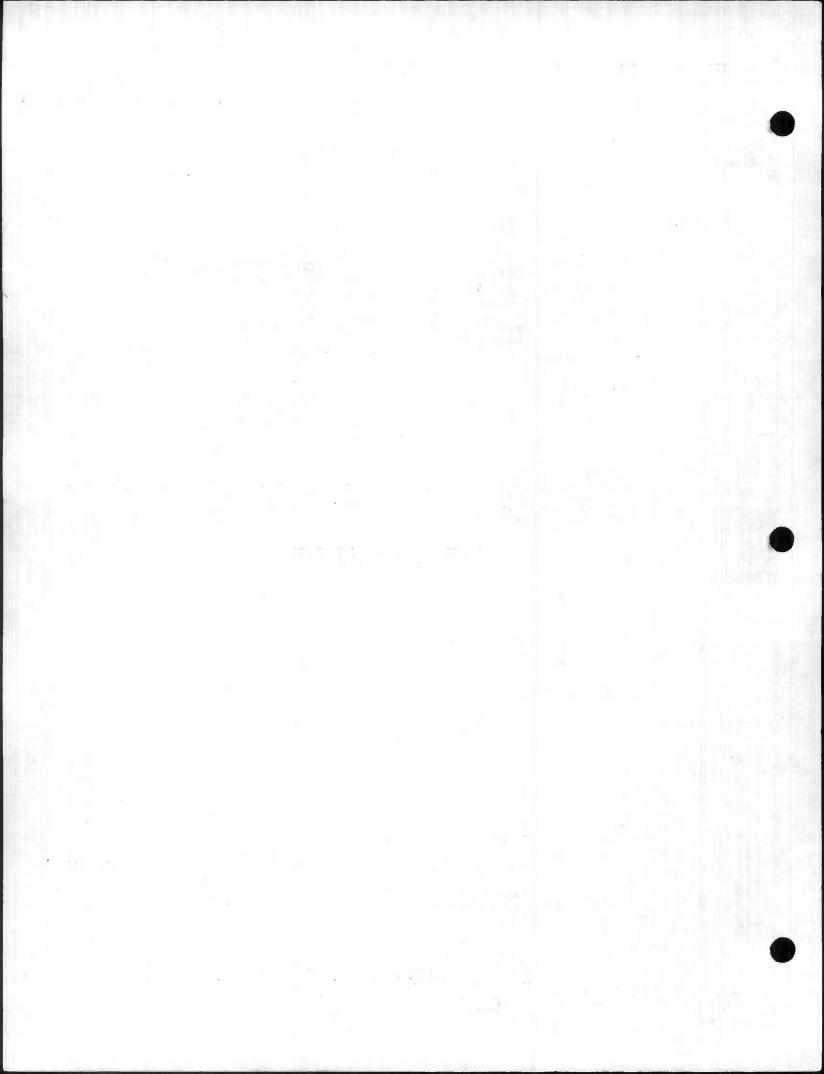
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ent of Health and Mental Hygiene

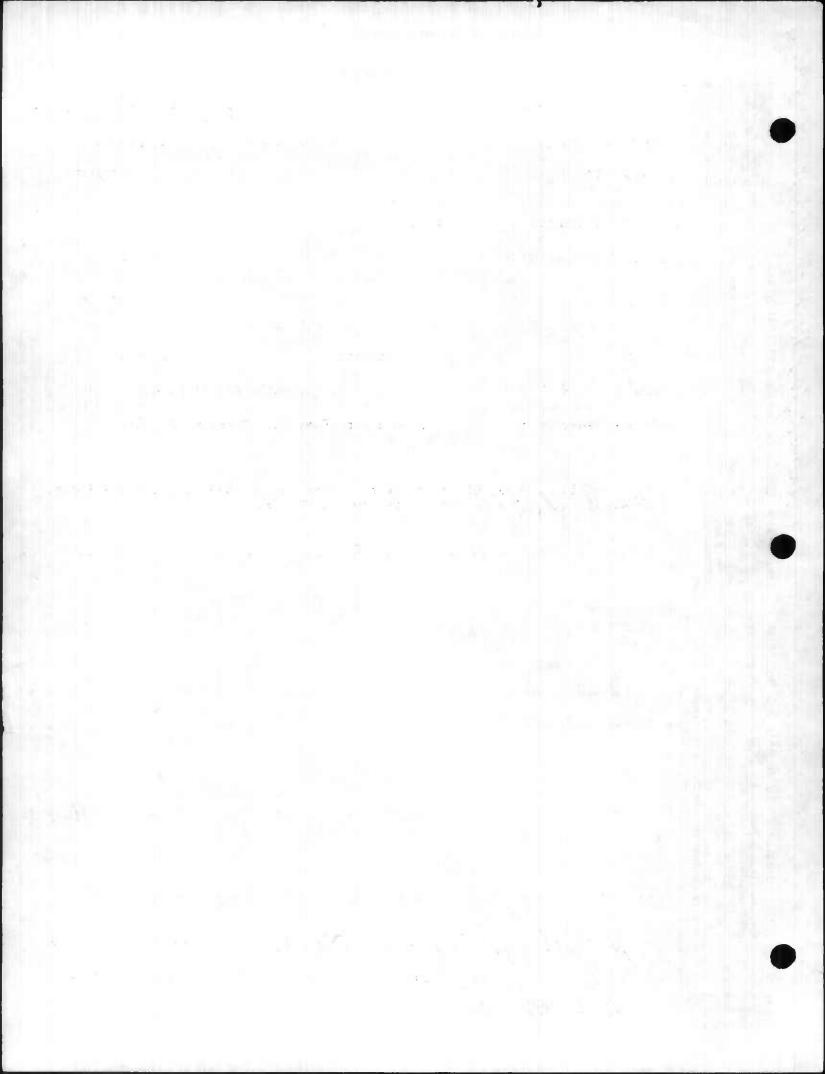
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	#23 PART I, 27 28A-  1. Decedent's Neme (First, Middle		2. Dete of Dec	30, 199	Year	3. Time of Death 11:40 AM.								
dical _	June Cliser  4e Facility Name (If not institution, give street and number)  4b. City, Town.										11:40 AM.			
niner	le Facility Name (If not institution,	give street and number)						ation of Death						
	1836 METZEROTT RD. APT. 427  ADELPHI  Prince Georges  5 Social Security Number 6 Sax 7 Ana (In vrs. last birthday)   ff Under 1 Year   lif Under 24 Hrs.   8 Date of Birth													
al or	5. Social Security Number unknown	6. Sax 7. Age 1	a (In yrs. last bir 44	thday) If Un Yrs. Mont	der 1 Year hs Deys		Min.	8. Date of Birt (Month, De June 20	, Year)	9. Birthpla Counti Mary	ace (State or Foreign y) land			
1	Usual Residence of Decedent													
-	10a. Stete 10b. County		10c. City, Tow	n or Location						10	d. Inside City Limits			
Directo	Maryland Princ	e Georges	Ade1pl	ni							1 ☐ Yes ZX No			
ire	10e. Street and Number			10f.	Zip Code				10g. Citizen of \	What Count	ry?			
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Funeral	11. Meritel Stelus	12. Wes Decedent I	Ever in U,S.	13. Was De	0783 cedeni of	Hispanic Ori	igin? (Spec	cify Yes or No	14. Rac	e - Amarica				
'n	1 ☐ Never Married 2 ☐ Merried 3 ☐ Widowed 4 🎇 Divorced	Armed Forces?  1  Yes 2  N  If Yas, Give Yeer or Detes:	ło			ban, Mexicar Specify:	-	lican, atc.)		ck, Whita, e v: whit				
Completed	15. Decedent	Education	16a.	Decedent's U	Isual Occu	pation		LVII	16b. Kind of B	usiness/Inde	ustry			
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2	Joseph L. Feuda	T				סמ	ris I	Javis	er, City or Town, State, Zip Code)					
	19a. Informent's Neme/Relationsh	p (Type, Print)	19b	. Mailing Addr	ess (Stree	et end Numbe	er or Rural	Route Number	er, City or Town,	State, Zip	Code)			
	Doris Feudal/mo	ther	RI	) 1, Bo	x 12	96. Th	ree S	Springs	, PA 1	7264				
	20e. Method of Disposition  1 Burial 2 Cremation  4 Donetion 5 Other (Sp	3 ☐Removel from State	20b. Place o	Disposition ( ry, cremetory	Name of			Date	20c. Location -		vn, Stata			
	21. Signelure of Fundrel Service Licensee Ronald S./Wade, Director Ronald S./Wade, Director Baltimore, MD 21201													
	23a. Part1. Enter the disease, or chock, or heert failure. List of	orhplicetions that caused nly one ceuse on each lin	the death. Do			·			rest,	1	Approximete Interval Between Onset and Death			
	Immediate Cause (Finel disease or condition resulting in death)  NARCOTIC AND ALCOHOL INTOXICATION  Due to (or as a consequence of):													
Je.			D00 10 (01 as a	consequence	0.7.					1				
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying	b	b Due to (or as a consequence of):											
8	Ceuse (Disease or injury that initiated events resulting in deeth) Last  Due to (or es e consequenca of):													
		d								1				
Physician	Pert II. Other significant condition	a contributing to death bu	ut not resulting in	n the underlyin	ng cause g	iven in Pert I	l.	23b. Did tobacco use contribute to the cause of death?						
Dy C								10	2010	3 7 700	ably 4 dilkilowii			
Completed								24e. Was an autopsy performed?  24b. Were autopsy fir available prior to completion of ca			ilable prior to			
E								10	of death?					
١								181		1	Yes 2□ No			
ומ	25. Was case referred to medical examiner?	Hoeniteli					e of Deeth	(Check only o	ne)					
2	1 XYes 2 No	Hospitel: 1 Inpatie	nt 2□ER/Ou	rtpatient 3	DOA		ursing Horr	ne 5 🕅 Resid	tence 6 □Ott	ner (Specify	)			
	27. Menner of Deeth	28a. Dete of Injur (Month, Day	Year) 28b.	Time of njury	28c. Inji	ury all ork?	2	28d. Describe how injury occurred						
atic	1 Netural 5 Pending 2 Accident invastig	FOILING *		nown M		Yes 2	No	UNKNOWN						
Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify)  HOME							28f. Location (Street and Number of Bural Fours Number, City or Town, State) 1836 METZERUT RUAD ADELPHI, MD						
	(Check only 2 Madicat E	Physician: To the best of kaminer: On the basis of	examination an	, death occur d/or investigat	red at the t	ime, date en opinion, dea	d place, e	nd due to the	cause(s) and ma	anner as sta and due to	nted. the cause(s)			
	one) 29b. Signature and title of certifier,	end manner ste	red.		29c. Licer	se number			29d. Date signe	od (Month. L	Day, Year)			
	· Mount	me Shell	/			o.c.	M.E.			, 199				
3	90. Name and address of person w	ho completed cause of de			reet	, Balt	imore	e, Marv	land 21	201				
tate 3	31. Data filed (Month, Day, Year)	32. Registra	r's Signature	4	/	4								



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 1999 5:40 pm Dorothy Ruth Carman May 18 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Death Examiner Baltimore | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb. 20, 15 Gilchrist Center Baltimore If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1□ M 25 F Days 79 Director 215-14-5797 Maryland Usual Residence of Deceden r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland Baltimore Glen Arm 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "netural", or items 23e or the Medical Examiner must be. 21 Gun Powder Road 21057 U.S.A. Funeral 12. Was Decedent Ever In U.S. Armed Forces? 1 Pes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: white py 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Hygiene. 12 secretary church marked other permit. Pages 1 and 2 should be file Department of Health and Merkal Hy Important: If Nem 27 is marked oths any Injury or other traumatic event. 17. Father's Name (First. Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Edward James Smith Dorothy Elizabeth Ruth 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kristine Bauer/neice 190002 Hunt Pass Ct., Parkton, MD Baltimore, 20b. Place of Disposition (Neme of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 XDonation 5 ☐ Other (Specify) 21 Signature of Funeral Service Licenses 22. Name and Address of Facility Director Ronald S Wade State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Deeth **Physician** colo-rectal CANCER /Medical Immediate Cause (Final 10 months disease or condition resulting in death) Examiner Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): Box 68760 Physician/Medical Due to (or as a consequence of) 88 signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? peed completion of cause of death? page 2 has 1 Yes 20 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Attending Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hosyico Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No P this funeral 27. Menner of Death 28a. Dete of Injury (Month, Dey Yeer) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Naturai death. 1 ☐ Yes 2 ☐ No 2 Accident or Attend after death Director: 3 Suicide 6 Could not be determined n 24 hours after de le Funeral Directo pletely filled in by the 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 26f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Hospital edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier within 24 hou To the Fune completely fi the 29b. Signature and title of ce 29d. Date signed (Month. Dev. Year) 29c. License number D25205 mo 6701 N. Charles St. Balto. md 2120 32. Registrar's Signature State Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item: 20b per F.H G-771 5/28/99 reb Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Deta of Death Month Yeer ELIZABETH CLAYBROOKS 23 12:50 P.M MAY 1999 4a. Facility Nema (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE If Under 24 Hrs. 8, Date NURSING CENTER CHURCH 8. Dete of Birth (Month, Day, Yaar) S. Charolina Inalda City Line 1. Cauntry) Inalda City Line 5. Social Security Number If Undar 1 Yaar 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 1 M 2 XF Days Hours 219-20-8494 Yrs 82 Usual Rasidance of Dacedant 10a. Stata 10h County 10c. City, Town or Location 10d, Insida City Limits JEYes 2□ No BAIH MUYE Yary/oro 10e. Streat and Numbar 10f. Zip Coda 10g. Citizan of What Country? 123 W. 29th 21218 USB 12. Wes Decedant Evar in U,S. Armad Forces? 1 ☐ Yas 2 2 No If Yas, Giva Yeer or Datas: 11. Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puarto Ricen, atc.) Rece - Amaricen Indian, Black, White, etc. 1 Navar Married 2 Married 1□ Yes 2000 Spacify: specify: Black Widowad 4 ☐ Divorced 16a. Dacedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use rating) House Wilks 15. Decedent's Education (Spacify only highast grada completed) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) 9th 9race OWN HONE Collaga (1-4or 5+) 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) CARRIE Price PERRY 19a. Informent's Name/Ralationship (Type, Print) SHIKLEY DILATO (DA 19b. Melling Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) SHIKLEY DAUghter 4108 GlEW HUNT RUMO BALTIMOR, Med 21229 5/28/189/ 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 Cramation 3 ☐ Removal from Stata Baltinore, no anetery ENHOUNT 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signetura of Funaral Service Licensaa 22. Nama and Address of Fecility CHATMAN HARRIS FUNCION HIMC 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying/such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onsat and Death Immediate Cause (Finel CEREBROVASCULAR disaase or condition resulting in daath) Dua to (or as e consequance of): Sequantially list conditions, if any, taading to immadiata cousa. Entar Underlying Cause (Diseasa or injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to completion of ceuse of death? 24a. Was en eutopsy performad? 2 No 1 ☐ Yes 2 ☐ No 25. Was cesa rafarrad to medical axaminer? 26. Place of Daath (Check only ona) 1 Yas 2 No Other: 4 M Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Many for of Death 28a. Data of Injury (Month, Day Year) 28b. Time of Injury 28d. Dascribe how injury occurred 28c. Injury at Work? 1 Naturel 5 Panding 1 Yas 2 No invastigation

The law requires that the death certificate be executed use es the burial-transit P.O. Box 68760, Records, hes Division of Vital or Attending Physician: this After

Physician/Medicai þ Completed Be

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Examiner

**Funerai** 

Director

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nt of Health a : If item 27 is or other tra

Department of Important: If any injury or

**Physician** /Medicai

Examiner

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Funeral

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Baltimore, Maryland

Certification: To

Medical

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State Registrar

31. Deta filed (Month, Day, Year)

29b. Signatura and titla of cartifies

2 Accidant

3 ☐ Suicida

29a. Certifian (Check only

4 Homicida

6 Could not be determined

auros

C. VERGARA - GOARES

MAY 2 8 1999

30. Name and address of person who complated ceusa of death (Item 23a) (Type, Print)

32. Ragistrar's Signatura

100 N. BROADWAY

28e. Placa of Injury - At home, ferm, streat, factory, office building, atc. (Specify)

1 Certifying Physician: To the bast of my knowledge, death occurred et the time, data and place, and due to the causa(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated.

29c. License number

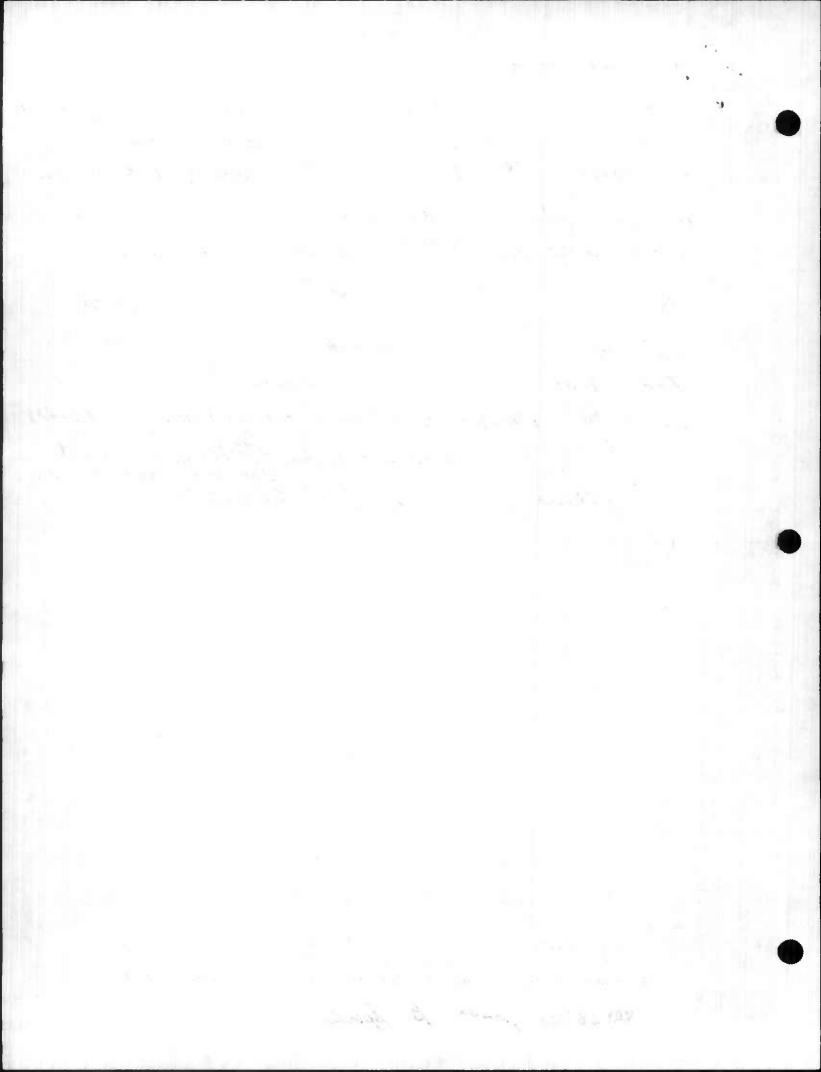
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57.

28f. Location (Street and Number or Rural Routa Number, City or Town, Stete)

BALTIMORE

29d. Deta signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician Helena B. Chojnowski May 25, 7:080.4 1999 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St. Elizabeth's Nursing Home Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1□M 2Ĭ F Vrs 217-09-0620 79 28, 1919 Maryland Usuet Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5919 Rowanberry Drive 21075 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Merried 1 Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 M Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) 8th College (1-4or 5+) Lens Grounder Optical Lab 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Walenty Wilczynski Mychalena Wojtysiak 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice C. Snyder / Daughter 5919 Rowanberry Drive, Elkridge, Maryland 21075 20b. Place of Disposition (Nema of 20a Method of Disposition 20c. Location - City or Town, Steta Dete cemetery, cremetory or other place) 1 ☐ Burial 2 【Cremetion 3 ☐ Removel from State Metro Crematory 5/26/99 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licenses 22. Name end Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 homos uanta Parts. Her the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, wheart feilure. List only one cause on each line. Approximeta Intervat Between Onset end Deeth Immediete Cause (Finat disease or condition resulting in death) meta static Examiner Sequentially list conditions, if any, leading to immediala ceuse. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Lasl Physician/Medical Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yee 2 ☐ No þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Wes en autopsy 1 Yes 2 No 1 Yes 20 No Be 25. Was cese referred to medicet 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 A Natural 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ∏ Yes 2 ∏ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 ☐ Homicide

The law requires that the death certificate be avacuted 68760 Box P.O. Records. Vital Physician: o To the Hospital or Attanding Pr within 24 hours after death. To the Funeral Director: After th completely lilled in by the funeral Division

**Funeral** 

Director

28a-f show

Herrs 23s

7 is marked other than "natural", or items 23s or 28s-f show traumedic avant, the Medical Examinal mark be notified at

pemilt. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hyglena. Important: if Itam 27 is marked other than "natural", or his any injury or other traumatic avant, the Medical Examina pages.

**Physician** 

/Medical

Examiner

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altimore, Maryland 21215-0020

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death

**DHMH 16 Rev 6/95** 

State Registrar

Ye lena 31. Dete filed (Month, Day, Year) MAY 28 1999

Yellea

29b. Signeture end title of certifier

29e. Certifier

29c. License number

29d. Date signed (Month, Day, Year)

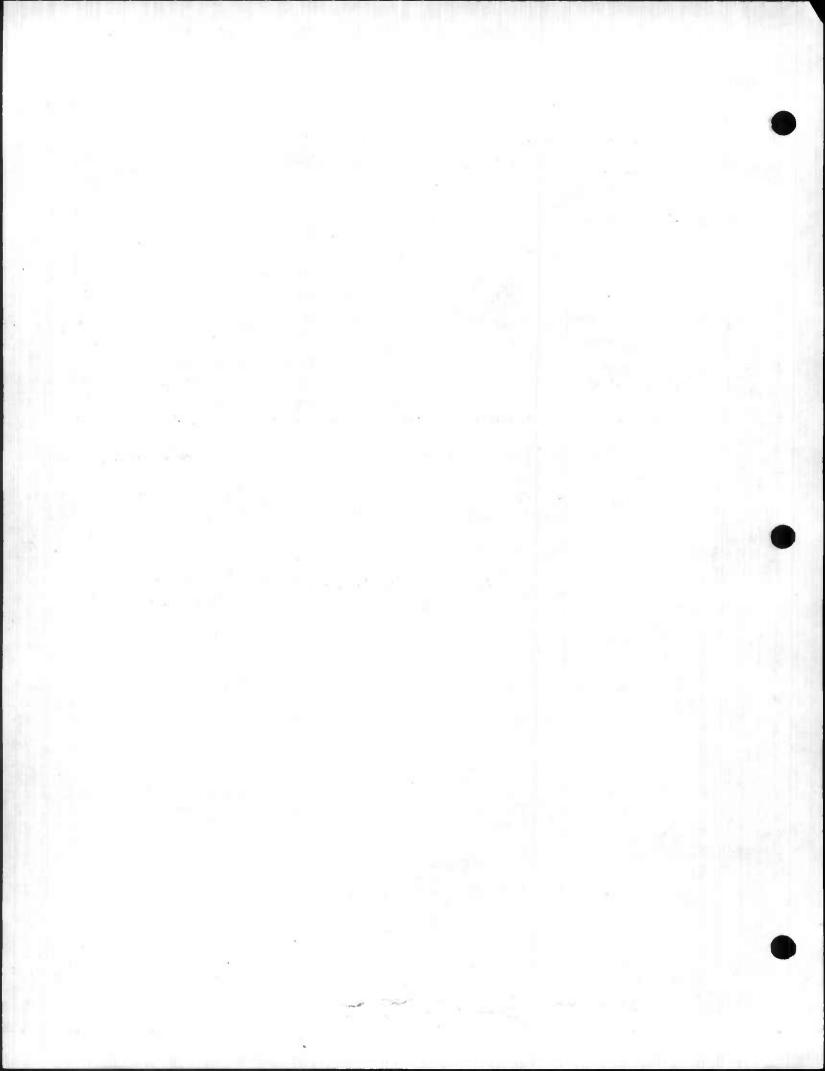
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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who compléted cause of death (Item 23a) (Type, Print) PNIK 720 41

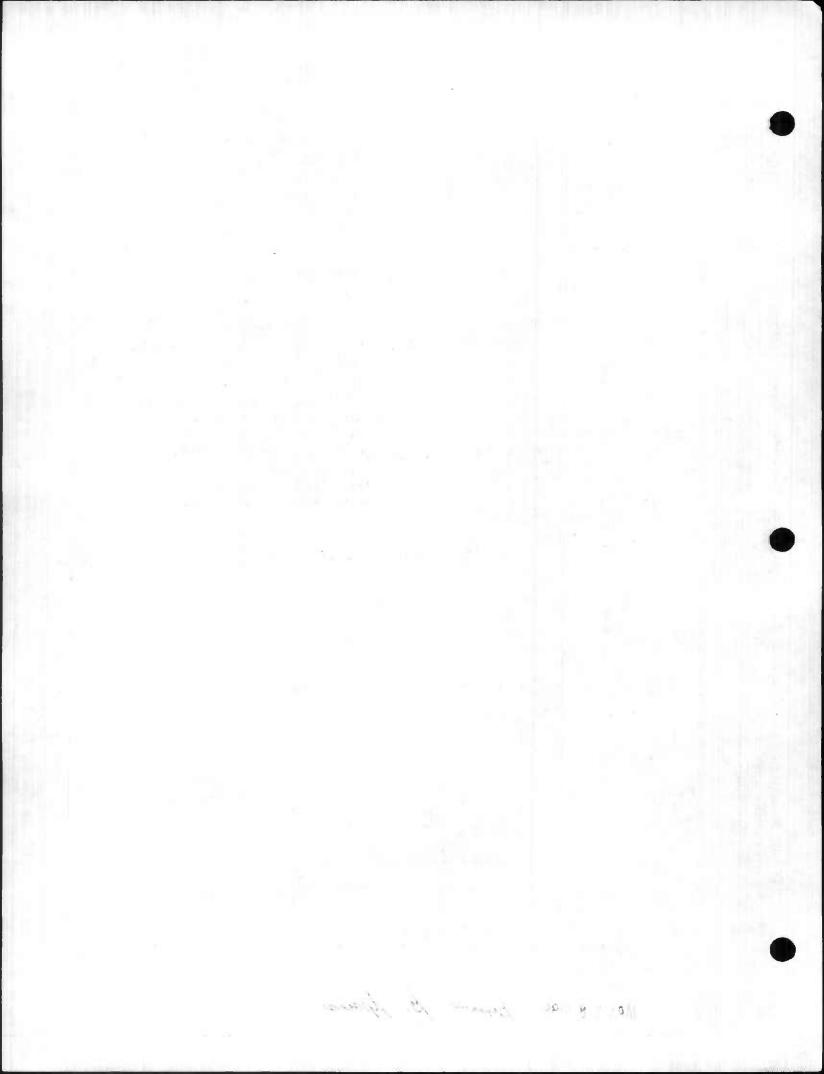
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22. Registrar's Signature



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

	I. Decedent's Name	/First. Middle.	ast)		Cei	tificate of	Death	2. Date of	Reg. No.	99	3. Tima of Death				
an cal _	n GARNET E COMBS								25 Day	25 1999 1					
ner	4a Facility Name (If not institution, give street and number) 4b. City.							or Location of De		County of Death Baltimo:					
5	. Social Security Nu		Sex Sex	7. Age (In yrs. last birthday) If Under 1 Ye											
	246–22–02	47	1□M 2⊠F	79	Yrs.	Months Days	Hours	Min. (Month, March	Birth Day, Year) 2 192	20 West	place (State or Foreig intry) Virginia				
-	Jsuei Residence of I	Decedent 10b. County		10c. City	y, Town or Lo	cation					t 0d. Inside City Limita				
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[	7. Father's Name (Frank		st)					Name (First, Mide adie C. E		Sumeme)					
	19e. Informent's Nar Nina Ka							ox Rural Route Nur Baldwin			p Code)				
2	Oa. Method of Dispo	osition Cremetion 3	☑Removel from		lace of Disposemetery, cren	sition (Name of netory or other ple	ce)	Date netery5/2	20c. Loc	ation - City or T					
21. Signeture of Funeral Service Licensee  22. Name and Address of Facility Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221															
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P	het initiated events esulting in death) Li	ast	Due to (or as a consequence of):												
P	art II. Other signific	ant conditions	contributing to d	eath but not resu	ulting in the ur	derlying cause gi	23b. Did tobacco use contribute to the cause of death								
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-	4,59								as an autops nformed?	6	Vere autopsy findings vailable prior to ompletion of cause f death?				
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	2 Accident 3 Suicide 4 Homicide	investiget  6 Could not determine	be an Dies	M 1□ set, fectory, office	28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)										
	9e. Certifier (Check only one)	Certifying i	miner: On the b	best of my know asis of examinat ner stated.	wledge, death ion end/or inv	occurred et the ti estigation, in my o	me, date end p opinion, deeth	place, end due to to occurred at the time	ne cause(s) a na, date end p	and manner as place, and due	stated. to the cause(s)				
-	9b. Signeture and ti	tle of certifie	with-	e Phi	Vana	29c. Licens	se number		29d. Date	signed (Month	, Dey, Year)				
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1		4 MACE		MARVI.AN	ID 213	21									
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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death May 12:268 **Physician** 1999 renda DUVOLON /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner BON Secours Hospital Baltimore NA If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Ye 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) if Under 1 Year Birthplace (State or Foreign Country) Days 1 M 2 F Months Yrs. 58 Vírginia 204-30-7636 Mar 29, Usual Residence of Decedent 10a. Stete 10d. Inside City Limits 10b. County 10c, City, Town or Location 1 XYes 2 No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1136 N. Stockton Street 21217 USA Funeral 12. Was Deceden! Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 25 No Specify: Black. Specify: þ 3 Widowed Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Dry Cleaners 12th Presser 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Howard Jordan Leona Stevenson Washington 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Monique N. Washington (Niece) 621 Yale Avenue 2nd Floor Baltimore, Md 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriai 2X Cremation 3 ☐ Removal from State 5/28/99 Catonsville, Maryland Metro Crematory 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Se 22. Name and Address of Facility Caple Funeral Service 5502 Winner Avenue Baltimore, Maryland 21215 3e. Part/ Enter the disease of complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, snock, or heer failure. List only one cause on each line. Approximete Intervel Between Onsel and Deeth disease or condition resulting in death) Due to (or es e consequence of): Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enler Underlying Couse (Disease or injury that Initiated events resulting in deeth) Last Due to (or es e consequenca of): lan/Medical Due to (or es e consequenca of): Physic Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy Completed 2 No 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical 26. Piace of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 1 Yes 2 No 2 DER/Outpatient 1 Inpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? 1 Maturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Decrtifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

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**Funeral** 

Director

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Department of Important: If any injury or

**Physician** /Medical

Examiner

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Attending

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Hospital

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physician 8

altimore, Maryland 21215-0020

State Registrar

31. Date filed (Month, Day, Yeer) MAY 28

ANIL UBEROL MD

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Derail

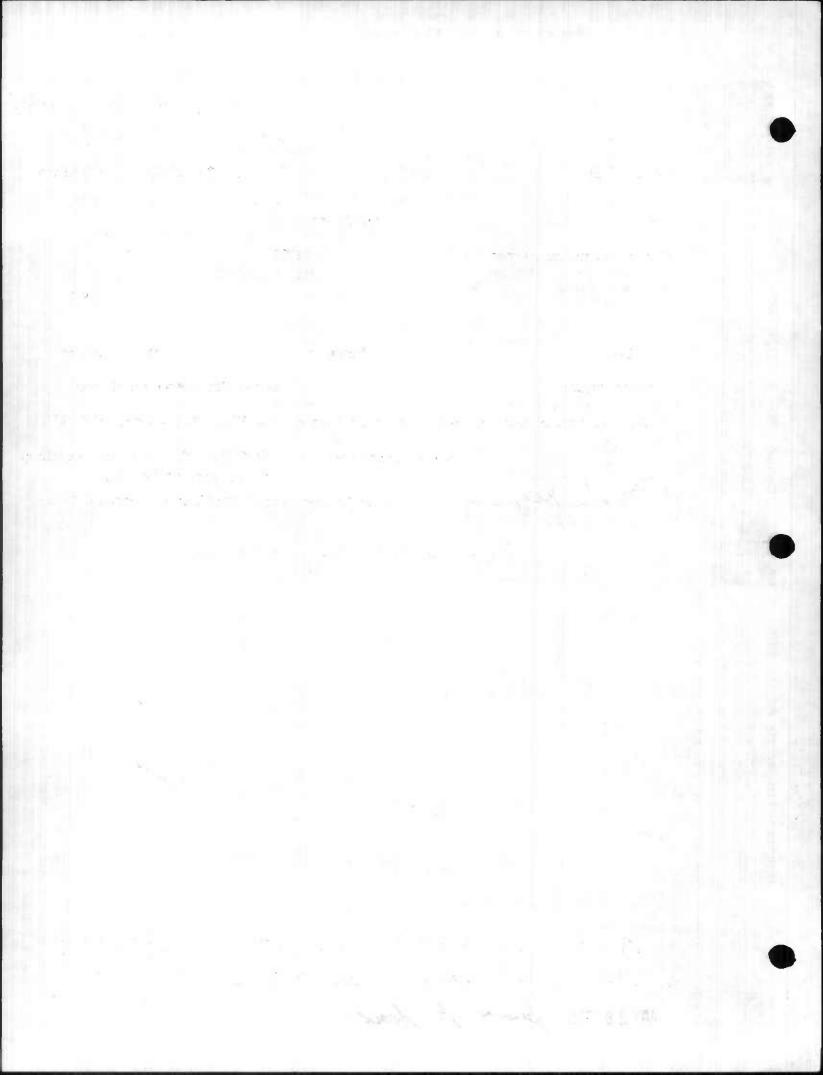
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29c. License number

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FALLS RO BALTOMD

29d. Date signed (Month, Dey, Year)



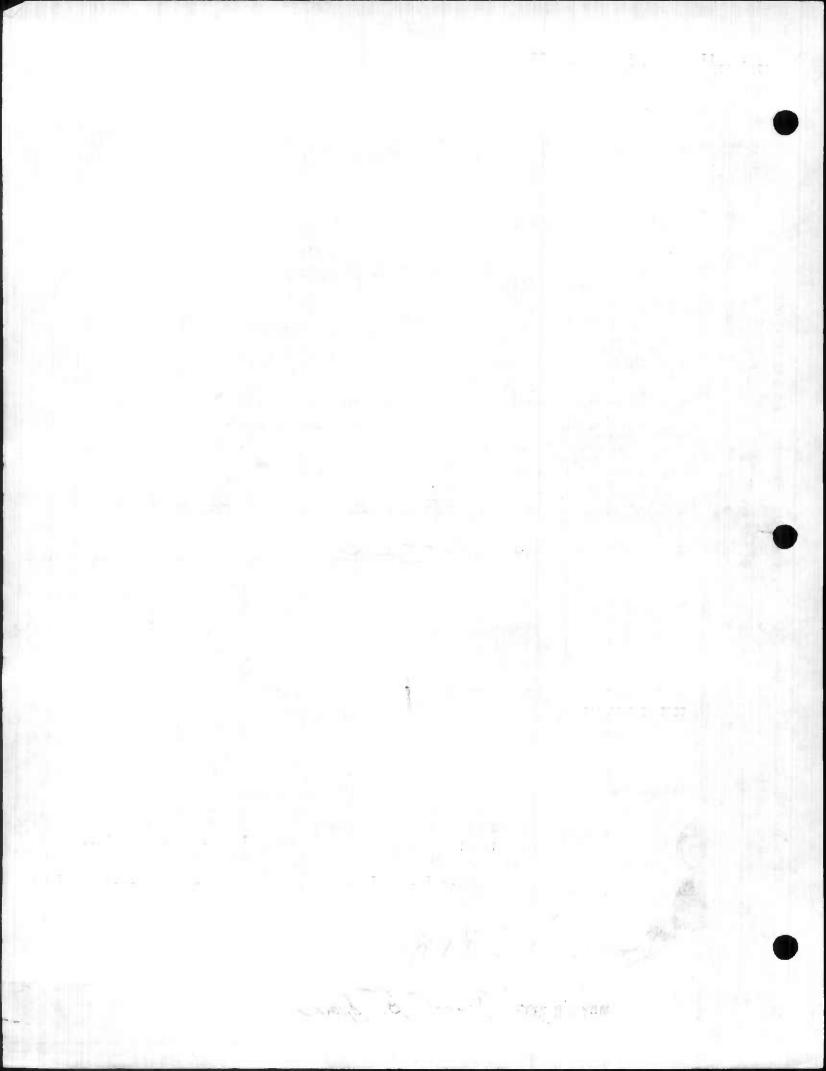
Piease Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. G 7 State of Maryland / Department of Health and Mental Hygiene AMEND ITEMS 28A-F PER MEO G775 6-21-99 WR.
AMEND ITEM: #23 PART II PER MD G772 6-21-99 WR. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Physician lai 12.55 pm /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Multi Medical enter 10WSON If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funera Months 215-09-256. Usual Residence of Decedent 100 M 2□ F Yrs Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No HMOR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ä b 21286 Berns 23s Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Zyes 2 No Wes, Give Year or Dates: WWIL 1 Never Married 2 Married Baltimore, Maryland 21215-0020 ò Specify: White 1 ☐ Yes 2 Ø No Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education acify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filled within a ment of Health and Mental Hyglene, and if farm 27 is marked other than "any or other traumade evant, as Men Elementary/Secondary (0-12) College (1-4or 5+) immer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sicond 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State May 25 cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furieral Say 22. Name and Address of Facility Evans Hardord Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **P**hysician Immediate Cause (Final disease or condition resulting in death) /Medical La, GrasorM. ataction 30Min Examiner Due to (or as a consequence of): Examiner sician and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician s the buria Physician/Medical Due to (or as a consequence of) P.O. Box MANUFORTON APPROVED Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part II. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yea 2 No 3 Probably 4 Unknown TEFT TIBIA FRACTURE þ Records. 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 a 1 Yes 1 ☐ Yes 2 No of Vital Attending Physician: director. 8 25. Was case referred to medical 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Tima of 28d. Describe how injury occurred Ather Division 5 Pending investigation ural TRIPPED OVER RUG FELL deeth. 1 ☐ Yes 2) ☐(No 2 Accident MAY 11, 1999 UNKNOWN within 24 hours efter deet To the Funeral Director: completely filled in by the 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide 10 SUPER FRESH STORE 823 DULANEY VALLEY RD. TOWSON Hospital 1) Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a Certifier ş 29b. Signature and title of pertific 29d. Date signed (Month, Day, Year) use of death (Item 23a) (Type, Print) pland OCH RAVEN BIVD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

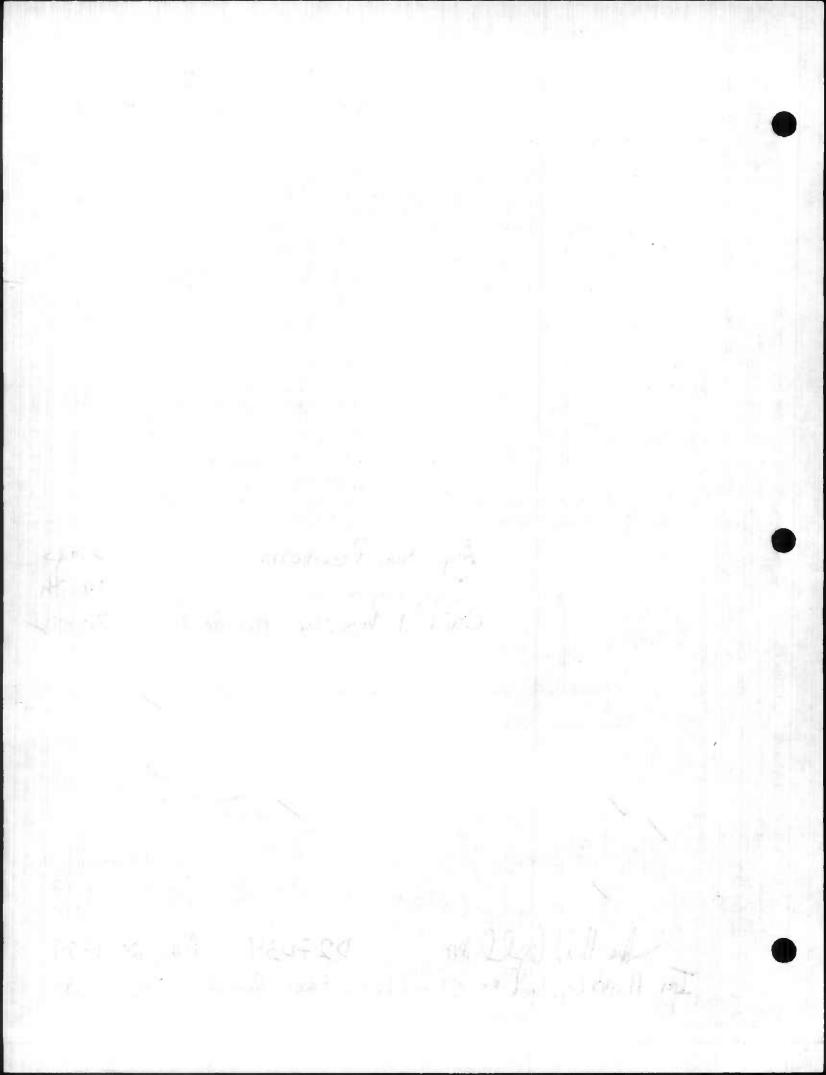
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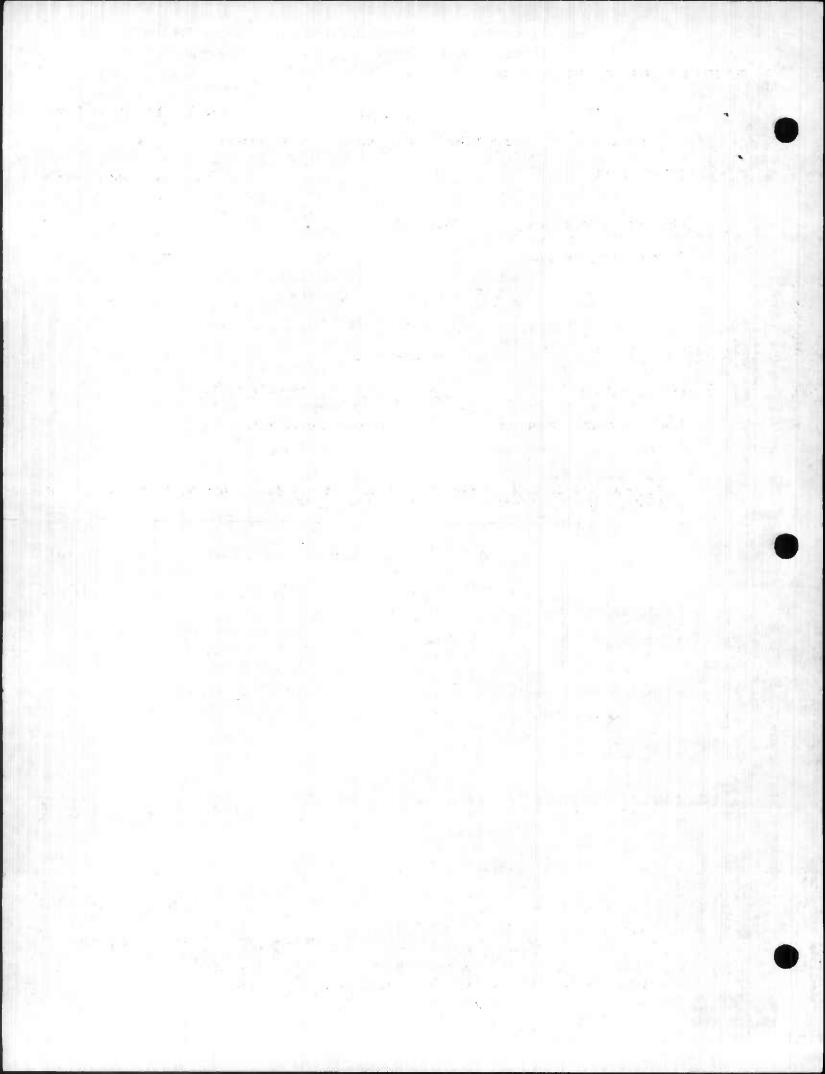
State of Maryland / Department of Health and Mental Hygiene 17000

				Ce	rtificat	te of	Death		Reg. No.		020	
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Medical	IDA E				DEC	JTCH		MAY	25			
kaminer	4a Facility Nama (If not institution	on, give street and n	umber)				4b. City, Town, or	Location of Deat	4c. Count	y of Death		
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eral tor	5. Social Security Number 218-44-4138	6. Sex 1 □ M <b>½</b> □ F	7. Age (In yrs	last birthday, Yrs.	Months	Days	Hunder 24 Hrs Hours Min.		th ly, Year) , 1908	9. Birthpl Count MAR	lace (State or Foreign try) YLAND	
	Usual Residence of Decedent  10a. State 10b. Count  N./	ity, Town or L						10	0d. Inside City Limits			
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letec	15. Decede (Specify only highe	15. Decedent's Education (Specify only highest grade completed)					pation during most of wo	rking	16b. Kind of E	Business/Ind	lustry	
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	17. Father's Nama (First, Middle	, Last)					18. Mother's Na	ma (First, Middle				
To Be	ISAAC	HE	ENDERSON	1			BESSIE	Ξ	LES	SER		
	19a. Informant's Name/Ralation MRS . HARRIET J		DAUG.)				and Number or R	BALTO.	_	1, State, Zip	Code)	
	20a. Method of Disposition		206.	Place of Disponentary, cre	osition (Na	me of		Data	20c. Location	- City or To	wn, Stata	
	1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (		n Stata				Z CHAIM	5/26/99	BALT	IMORE.	, MD	
8008	21. Signature of Funaral Sarvice	Licensee	7	2	2. Nama ar SOL	nd Addra	ass of Facility VINSON &	BROS.,I	NC.	Bay s		
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MENUEU I	IEM	# 24a PER M.D. G771 5/28/99 AH Certificate of Death  1. Decedent's Name (First, Middle, Last)								Joann	2. Date of	Reg.	No.		3. Time of Death		
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or 28	Director	10e. Street and Nu							10f. Zip Co	de			10g. Citizen of What Cou			ntry?	
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E 8 9		Ronald S. Wide Director State Anatomy Board, 655 W. Baltimore Street									Street						
CHIEF PROPERTY.		23a. if art1. Enter the diséase, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, k, or heart failure. List only one cause on each line.									Approximate Interval Between						
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To the Hospital or Attending Physician: The law requires the within 24 hours after death.  To the Funeral Director: After this centificata has been signed completely filled in by the funeral director, page 2 should be		3 Suicida 4 ☐ Homicide  4 ☐ Homicide						City or Town, State)									
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		30. Name and add	ress of neren	who cor	noleted cau	se of dea	th (Item 23a)	) (Type P	rint)					,	7		
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DHMH 16 Rev 6/95



### Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Month 24, LEROY M. EPPS MAY 1999 18:42 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death UNIVERSITY HOSPITAL BALTIMORE 6. Sex 1 M 2 F If Under 24 Hrs. H Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months Hours 213-46-0844 6-22-44 VA. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No N/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1720 E. 29th ST. 21218 USA 11 Marital Stetus 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 KINO Specify: Specify: BLACK Yeer or Detes: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) -9--0-DISABLED 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ALEXANDER EPPS GLADYS WILLIAMS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Neme/Reletionship (Type, Print) DOROTHY PRESTON(SISTER) 1720 E. 29th ST. BALTIMORE, MARYLAND 21218 20b. Plece of Disposition (Name of 20c. Location - City or Town, State 20e. Method of Disposition Data cemetery, cremetory or other piece) 1 Buriei 2 Cremetion 3 Removel from Stete MT. ZION CEMETERY 5-29-99 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MARYLAND 21. Signature of Funerel Service Licensee 22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. CFSP 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Dectr 23a. Pert1. Enter the disease, or complications thei caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart tailure. List only one cause on each line. Approximete Intervel Between Onset and Death Immediete Ceuse (Finel disease or condition resulting in death) leso Vaza Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown disense 24b. Were autopsy tindings evailable prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify)

/Medical Examiner

**Physician** 

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

or 28a-f show

Director

Funeral

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Completed

Be

20

i hydene. other than "natural", or thems 23s or 28s-f ehow rent, the Medical Examiner must be notified at

permit. Peges 1 and 2 should be file Department of Heelth and Mental Hy Important: if I tam 27 I a marked other any Injury or other treumatic event blace.

filed within 72 hours after

altimore, Maryland 21215-0020

Examiner been signed by the a should be detached t page 2 certificate edical Certification: To this filled in by the funeral After

Physician/Medical Completed by Be

The lew requires that the death certificate be axecuted P.O. Box 68760. Records, Division of Vital To the Hospital or Attending Physician:

within 24 hours after death. To the Funeral Director: A completaly

**DHMH 16 Ray 6/95** 

State Registrar

31. Dete tiled (Month, Dey, Year)

30. Name and address of person who completed cause of de

5 Pending investigation

6 Could not be determined

1 Yes 2 No

27. Manyer of Death

1 Neturel

2 Accident

3 ☐ Suicide

29e, Certifier

4 ☐ Homicide

29b. Signeture and title of certifier

32. Registrer's Signetura

1 Inpatient

28a. Dete of Injury (Month, Dey Year)

cause of deeth (Hem 23e) (Type, Print) OUNT Loyal Ave, Falto 21217

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated.

29c. License number

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

281. Location (Street and Number or Rural Route Number, City or Town, State)

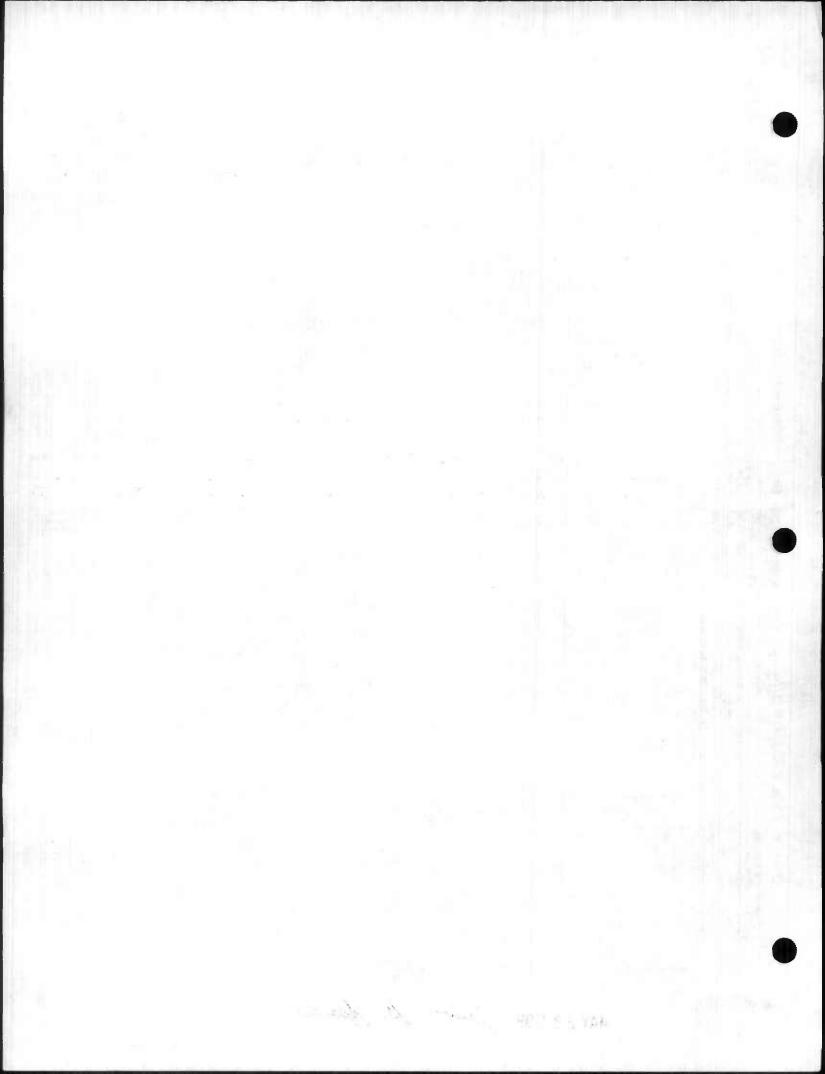
29d. Date signed (Month, Day, Year) 5-27.99

**ORIGINAL** 

2 FR/Outpatient 3 DOA

28b. Time of

28e. Pleca of Injury - At home, tarm, street, tactory, office building, etc. (Specify)



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

		State of Man		artment of ertificate o		ind Mental	Hygiene Reg. No.	99	/09	3	
	1. Decedent's Name (First, Middle, Last	1)		of Death	3. Time of De	3. Time of Death					
Physician	Gustav C.			Mont		1999	2:50	РМ			
/Medical Examiner	4a Facility Name (If not Institution, give	street and number)			4b. City, Tov	wn, or Location of		ounty of Death	2.30		
LXammer	1815 Dunmere R	d			Dund	lalk	Ba	altimo	re		
uneral	5. Social Security Number 6. Se	x 7. Age (//	n yrs. last birthday	If Under 1 Ye	ar If Under		of Birth th, Day, Year)		piace (Stete or F	oreign	
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Under Day	The state of the s	r in U,S. 13.	Was Decedent of if Yes, specify C	of Hispanic Orig uban, Mexican	gin? (Specify Yes , Puerto Rican, etc.	or No- c.)	. Race - Americ Black, White,				
Examiliary F	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give					S	pecify: Whi	ite		
	15. Decedent's Edu	Year or Dates:	16a Done	dent's Usual Oc	nunation.				Business/Industry		
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9 0	Gustav Ellinge	er			Ann	a Tanbu	sch				
-	19a. Informant's Name/Reletionship (Ty	rpe, Print)	19b. Meili	ing Address (Stre	et and Numbe	r or Rural Route N	Number, City or T	own, State, Zic	m. State. Zin Codel		
2 11	Elenora Ellino	ger /wife	e 181	5 Dunme	ere Rd	Balt	imore,	MD 21	222		
e de	20a. Method of Disposition		20b. Place of Disp			Date	20c. Loca	tion - City or To			
6	1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)			n Ceme		May 2		imore	, MD		
in a	21. Signature of Funeral Service Licans										
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	23a. Part 1. Enter the disease for complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line.  7110 Sollers Point Rd 21222  Approximate interval Between										
cian	shock, or heart lailure. Ust only or	ne cause on each line.	U		, ,	out of the party	ory amost	1	Approximate interval Betwee Onset and Dea	en ath	
ical	Immediate Cause (Final										
iner	disease or condition resulting In death)  a. In the state of the state										
ig in		W	e to (or as a conse	quence on:	1			1/	1400		
ounal-transit	Sequentially list conditions.  Due to (or as a consequence of):										
Ä	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.										
Icai	The implisted events  Due to (or as a consequence of):										
Physician/Med	resurring in death) Last										
200		d						1			
Sici	Part It. Other significant conditions con	ntributing to death but ne	ot resulting in the u	inderlying cause	given in Part i.	23b.	Did tobacco us	e contribute to	o the cause of c	death?	
Phy Ph							1 Yes 2 No 3 Probably 4 Unit				
2 2											
Completed						24a.	Was an autopsy performed?	av	ere autopsy find ailable prior to		
npie						_		of	mpletion of cau death?	20	
Comp							1 □ Yes 2 💢	No 1[	☐Yes 2☐ No	0	
Be i	25. Was case referred to medical examiner?				26. Place	of Deeth (Check	only one)				
I director, pag	1 ☐ Yes 2 No	lospital:	2 ER/Outpatie	nt 3D DOA	Other: 4 Nu	rsing Home 5	Residence 8 [	Other (Specif	(y)		
on:	27. Msnner of Desth 1 ☑Natursl 5 ☐ Pending	28a. Dete of Injury (Month, Day Ye	ear) 28b. Time of	of 28c. in	ijury at Vork?	28d. Desc	cribe how injury o	occurred			
the t	2 Accident investigation			M 1	☐ Yes 2☐N	No .					
led in by the funeri Certification:	3 Suicide 4 Homlcide  6 Could not be determined  28e. Placa of Injury - At home, farm, atreet, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
D 0											
<u>•</u> 0	(Check only 2 Medical Examin	ner: On the basis of exa	aminetion and/or in	h occurred at the	tima, date and	d place, and due to h occurred at the	o the cause(s) ar	ace, and due to	tated. the cause(s)		
tely fille											
npletely fille		29b. Signature and title of certifier 29c. License nu							Day, Year)		
Completely tile			D14221 5.								
completely fille	29b. Signature and title of certifier	78		D	142	2-1	S	. 26	28		
completely fille	29b. Signature and title of certifier  30. Name and address of person who co					2-1	S	. 26	28		
pletely fill edical	29b. Signature and title of certifier	i, M.D.	223 Eas		lvd	Essex,			28		

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State Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent'a Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death May 24, 1999 C. Lillian 10:02p.m. Fckert. 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Dulaney Towson Health Care Center Baltimore Towson If Under 24 Hrs. If Under 1 Year 8. Data of Birth Month, Day, Year October 14, 1904 5. Social Security Number 9. Birthplaca (Stata or Foreign 7. Aga (In yrs. last birthday) Days Months Hours Baltimore City, MD 1□ M 2□ F 215-03-8361 Usual Rasidence of Decadent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limita Baltimore Baltimore County 1 ☐ Yas 2 No Maryland 10e. Street and Number 10f Zin Code 10a. Citizen of What Country? 21234 8915 Avandale Road USA 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puarto Rican, atc.) 11 Marital Status Was Decedant Evar in U,S. Armed Forcas? 14. Race - American Indian. Black, Whita, atc. 1 Nevar Married 2 Married I ☐ Yas 2 ☒ No If Yas, Giva 1 Yas 2 No Specify: Specify: White 3♥ Widowed 4 Divorced Yaar or Datas 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Collega (1-4or 5+) NA Elamentary/Secondary (0-12) 12 Manager Retail 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Caroline Graham George Stanley Harrison 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Howard L. Mallon P.O. Box 550631 Jacksonville, Florida 32255 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 A Burial 2 Cramation 3 Ramoval from Stata Gardens of Faith Cem. May 28, 1999 Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funaral Sarvice Licansaa 22. Nama and Address of Facility Lassahn Funeral Home, Inc. 7401 Belair Road Baltimore, Maryland 21236-4625 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death Chronic Obstructive Pulmonary Disease tmmediata Causa (Final yens disaasa or condition rasulting in death) Dua to (or as a consequence of): Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Toknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yas 2 ☐ No 26. Placa of Death (Check only one) Hospitat: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 ☐ Rasidence 6 ☐ Other (Specify)

**Physician** /Medical Examiner

8

Department of Important: If any Injury or

**Physician** 

/Medical

Examiner

**Funeral** 

Director

Phone

ma 23a or 28a-f should at

Heme:

0

Director

Funeral

Be Completed by

with the Maryland

death

Pages 1 and 2 should be liled within 72 hours efter nent of Health and Mental Hygiene. Int: If Item 27 le marked other than "natural", or its

Baltimore, Maryland 21215-0020

Box 68760.

Records, P.O.

of Vitai

Division

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The law requires that the death certificate be executed the burial-trar 88 igned by the a page 2 certificate or Attending Physician: funeral director, this Affer

Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disease or Injury that initiated avents rasulting in death) Last Physician/Medical Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. Completed by Be 25. Was casa rafarred to medicat 1 Yas 2 No Medical Certification: To 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. tnjury at Work? 5 Panding Invastigation 1 Naturat 1 ☐ Yas 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accidant 6 Could not be datarmined 3 Suicida 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 Homleida Hospital 29a. Cartifiar (Check only one)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and titla of certifier

29c. License number D0053642 29d. Data signed (Month, Day, Year)

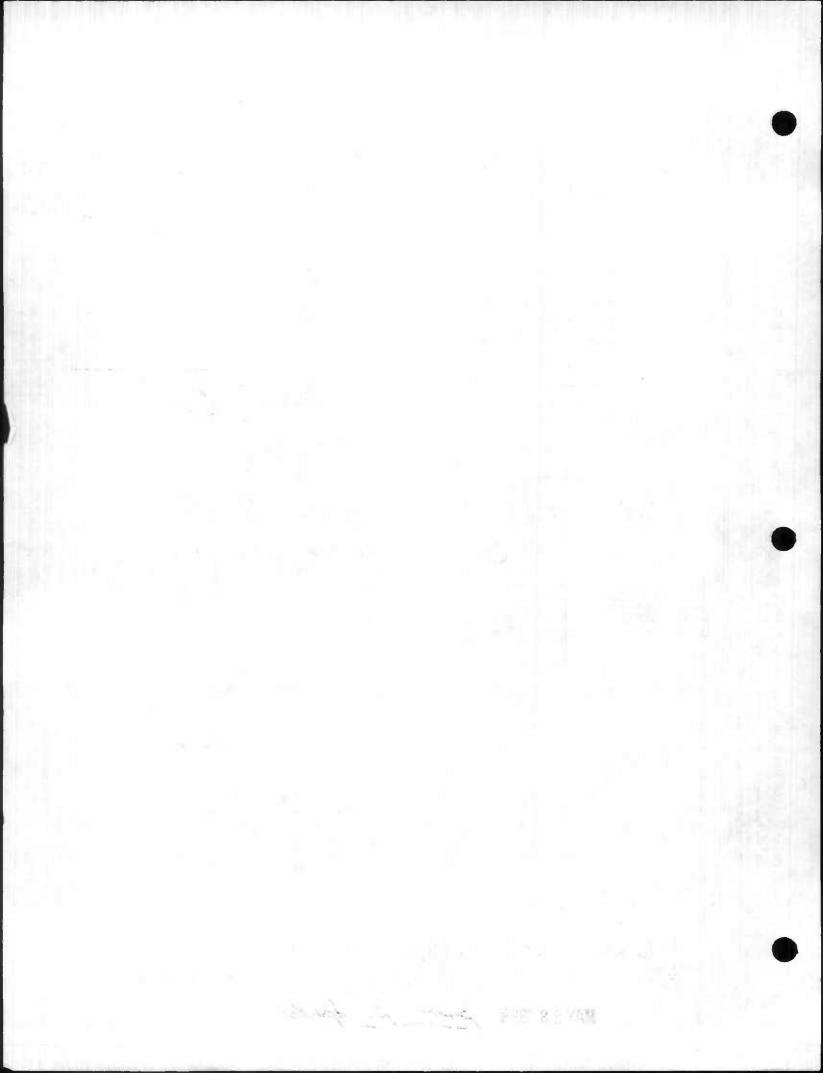
30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

Norther Parkway Bultimore MD. 21214 MIMO 21431 31. Data filed (Month, Day, Year)

State Registrar



**DHMH 16 Rev 6/95** 



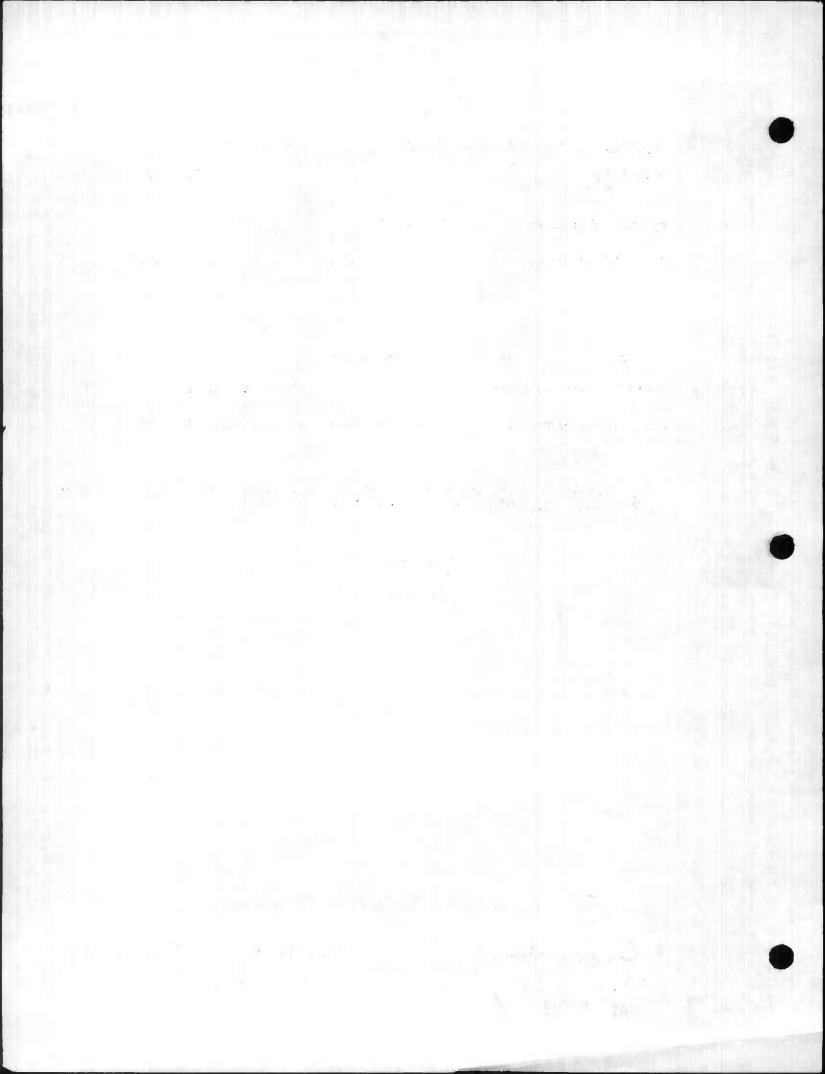
# Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99

Certificate of Death. 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death **Physician** Barbara 1999 10 18 MAGIOI /Medical 4b. City, Town, or Location of Deel 4e Facility Neme (If not institution, give street end number) 4c. County of Deeth Examiner ot Maryland

7. Age (In yrs. last birthday) MOR MIKE ff Undar 24 Hrs. ff Under 1 Year 5. Social Security Number 6 Sex 8. Data of Birth (Month, Day, Year) Birthplaca (Steta or Foraign Country) **Funeral** Min 1 □ M 2 1 F Months Days Hours Yrs. 133-20-4414 70 Director 3, 1928 New York Usual Rasidance of Decedant with the Maryland 10a State 10h Counts 10c. City. Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "naturel", or items 23a or 28a-f shov traumatic avent, ine Medical Examinat must be notified at 1 Yas 2 No Directo Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 101 Montrose Avenue 21228 U.S.A. deeth Funeral 12. Wes Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 1 No If Yes, Give Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-ff Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Rece - American Indian. 11. Maritaf Status permit. Pages 1 end 2 should be filled within 72 hours after c Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "naturel", or iten eny injury or other traumatic avent, in Medical Emirina. Black, Whita, atc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: white p 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedant's Education (Spacify only highest greda complated) 16h. Kind of Business/Industry Efamentary/Secondary (0-12) Coilega (1-4or 5+) 5+ 12 Own home Homemaker 18. Mothar's Nama (First, Middla, Maiden Sumama) 17. Fathar's Nema (First, Middle, Last) Donald Colebrook Miller Elizabeth Burns 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Robert D. Field/husband 101 Montrose Avenue, Catonsville, MD 20a. Mathod of Disposition 20b. Place of Disposition (Nama of camatary, crematory or other placa) Data 20c. Location - City or Town, State ☐ Buriel 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 Donation 5 Othar (Specify) 21. Signature of Fungisi Service Licensee 22. Name and Addrass of Facility Ward on Di Ronald S. Director State Anatomy Board 655 W. Baltimore Street 21201 Well 1 Baltimore, MĎ 4 23a. Per II. Enter the diseasa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Daeth **Physician** /Medical Immediete Ceuse (Finel disaasa or condition resulting in deeth) preumonia Examiner o (or as a consequence of) Examiner ulevni 9 lew requires that the deeth certificate be executed Sequantially list conditions, if any, laeding to immadiata cause. Enter Undarlying Causa (Disaasa or Injury that initiated avants resulting in daeth) Lest and Dua to (or as a consequence of) physician ar s the burial-to Box 68760. Physician/Medical Due to (or es e consequence of): for use es 23b. Did tobacco use contributs to the cause of death? ed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. signed by t 1 Yss 2 No 3 Probably 4 Unknown A 24b. Were autopsy findings aveilable prior to 24a. Wes en autopsy Completed peen complation of causa of death? hes page 2 The 1 Yas 2 No 1 ☐ Yes 2 ☐ No certificata the Hospital or Attanding Physician: director, 25. Was casa rafarrad to madical axeminer? Be 26. Pleca of Death (Check only one) Hospital: Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yes 2 No 1- Inpatiant Certification: To 2 ER/Outpatient 3 DOA this funerai 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? Aftar 1 Naturei 5 Pending death. invastigation 1 Yas 2 No 2 Accident Director: / 6 Could not be detarmined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of fnjury - At homa, farm, straat, factory, office building, atc. (Spacify) 4 Homicide in 24 hour. the Funeral Directory filled in edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to tha causa(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the ceusa(s) and manner stated. within 2 To the I 29d. Dete signed (Month, Dav. Year) 29b. Signatura and titla of certifiar 29c. Licansa number 30. Nama end eddrass of person who complated causa of death (ftem 23a) (Type, Print) th 22 Corecne 32 Registrar's Signature State

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Day **Physician** Year IDA May 24, 1999 ath 4c. County of Death 0350 /Medical 4b. City, Town, or Location of Death 4a. Facility Neme (If not institution, give street end number) Examiner Sinai Hospital of Balkmore Citi N/A Battimore If Under 24 Hrs. if Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2XF Deys Months Hours 215-22-5826 74 Vre MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE BALTIMORE Director 1 ☐ Yes 2X No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 7412 MONITA ROAD 21208 U.S.A. Horne 23a Funeral permit. Pages 1 and 2 should be fired within 72 hours after dean Department of Health and Mental Hygiens. Important: If Item 27 is marked other than "natural" any Injury or other traumatic event. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2XXNo if Yes, Give Yeer or Dates: 1 ☐ Never Married 2 X Merried 1□ Yes 2 No À WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father'a Name (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) Be MORRIS SALTZMAN ANNA WOL 2 19e. Informent's Neme/Relationship (Type, Pnint) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) HAROLD FRAMM / HUSBAND 7412 MONITA ROAD - BALTIMORE, MD 21208 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1XXBuriel 2 Cremation 3 Removal from State 5/25/99 ARLINGTON CHIZUK AMUNO BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Coneral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Fert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical **Examiner** Due to (or as e consequence of) Examiner Bladder Cancer The law requires that the death cartificata be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that Initieted events resulting in deeth) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 physician Physician/Medical Due to (or as a consequence of): signed by the attanding I Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Diabetes Mellitus Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy performed? Congestive Neart Fallure 2 No this cartificate 1 ☐ Yes 1 Yes 2 No I or Attending Physician: aftar death. Director: After this cartifica 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Atter within 24 hours after dea To the Funeral Director completely filled in by th 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stefe) 3 Sulcide 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) end manner as atated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year)

State Registrar

31. Dete filed (Month, Dey, Year)

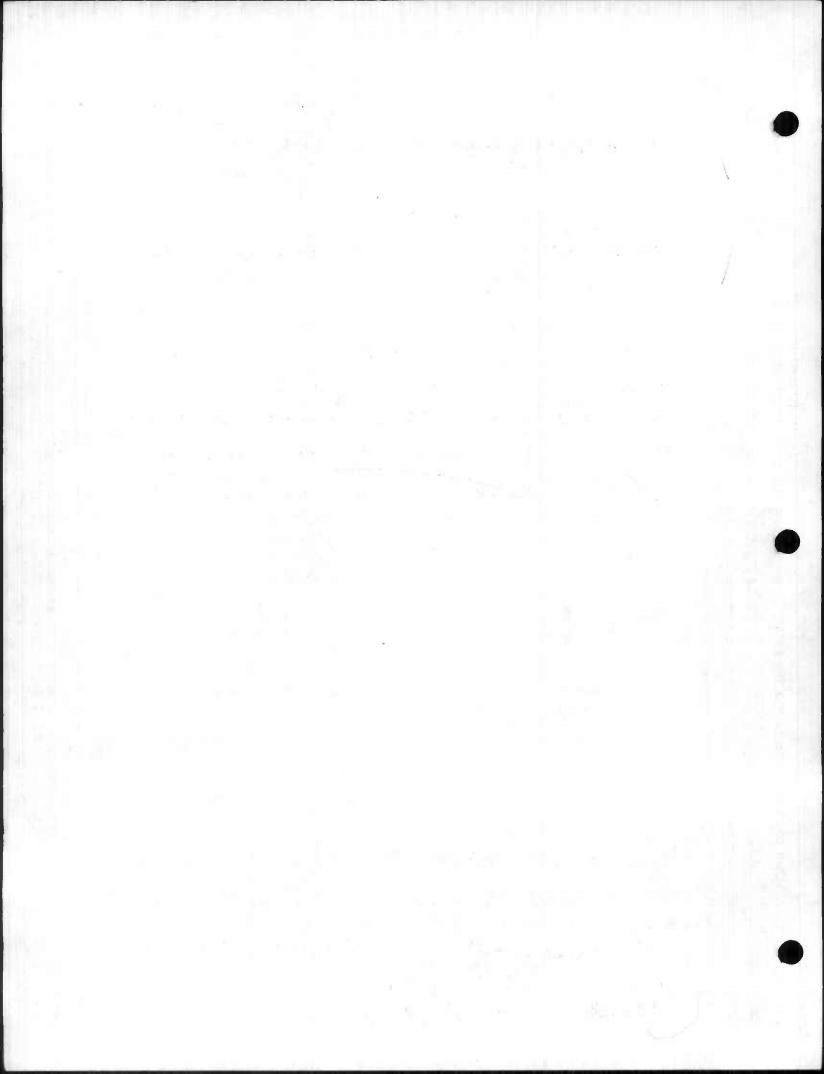
L K Bonaser MAY 2 8 1999

32. Registrar's Signature

Sinai Haspita

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

**DHMH 16 Rev 6/95** 



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item#5 perFH G772 6/30/99 EW 1. Decedent's Nama (First, Middle, Last) Certificate of Death Reg. No. 2. Data of Death 3 Time of Death Month 5 **Physician** Gervinski Joseph Michael 0 a 5:30 PM /Medical 4a Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Arbutus 5542 Carville AVR Bastimore If Undar 24 Hrs. 8. Data of Birth If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) 6. Sax Birthplaca (Stata or Foreign , Country) **Funeral** Year) 1 M 2 F Months Days 2200110 1918 Mn12 19,1918 Yrs. Director MARYLAND Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show BALTIMORE 1 Yes 2 No MID Director ARBUTUS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 ARVILLE AVE 21227 USA 5542 Нета 23а 12. Was Decedent Evar in U,S. Armed Forcas? 1 Yas 2 □ No If Yes, Giva 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11. Marifal Status Black, Whita, atc. 72 hours after 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yas 2 No Specify: p WHITE 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry iii. Pages 1 and 2 should be filed within: imment of Health end Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) STEEL MAINTENANLE Q"T# 17, Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) GERVINSKI ANTONETTE GERYGONIS MICHAEL 19a. Informant'a Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) WIFE AVE , ASSITUL MD 21227 MILDRES M. GERVINSKI SSAZ CARVILLE 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 Cramation 3 ☐ Ramoval from Stata 531 99 CATOMSVILLE, MD 4 ☐ Donation 5 ☐ Othar (Specify) METRO CREMATORY 22. Nama and Addrass of Facility AM BILO SEE FUN ERAL 21. Signature of Funeral Service Consee 1328 SULPHUR SPRING ROJ ARBUTUS MD 21227 23a. Part1. Entar tha disasse, or complications thet caused tha death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or haart feilura. List only ona ceuse on each line. Approximeta Intarval Between Onset and Death **Physician** /Medical Immediata Causa (Finel CELL CARCINOMA OF TWO YEARS disaasa or condition rasulting in daath) Examiner LEFT LUNG Examiner physician and the burial-tren Sequentially list conditions, if any, leading to immadiata causa. Entar Undarfying Cause (Diseasa or injury that initiated events rasulting in death) Lasf Dua to (or as a consequence of): Box 68760. Physician/Medical Dua to (or as a consequence of): the P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 ☐ Unknown ARTERY DISEASE bengis be del Records, 24b. Ware autopsy tindings available prior to Completed 24a. Wes an autopsy performed? OBSTRUCTIVE LUNG DISEASE completion of cause of death? 1 Yas 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: after death. Director: After this certifica Be 25. Was casa referred to medical 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 MR Rasidence 6 Othar (Specify) Certification: To 1 Yas 255 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Deta of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Natural 5 Panding 1 ☐ Yas 2 ☐ No invastigation 2 Accident 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, farm, streef, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicida To the Hospital or A within 24 hours after To the Funeral Dire-completely filled in b 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and mannar as stated.

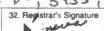
2 Medical Examiner: On the basis of axaminetion and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifiar 29c. License number

DHMH 16 Rav 6/95

State Registrar 31. Dete filed (Month, Day, Year) MAY 28 1999

Kanal le Rauf

30. Nama and addrass of person who completed causa ot death (Item 23a) (Type, Print)



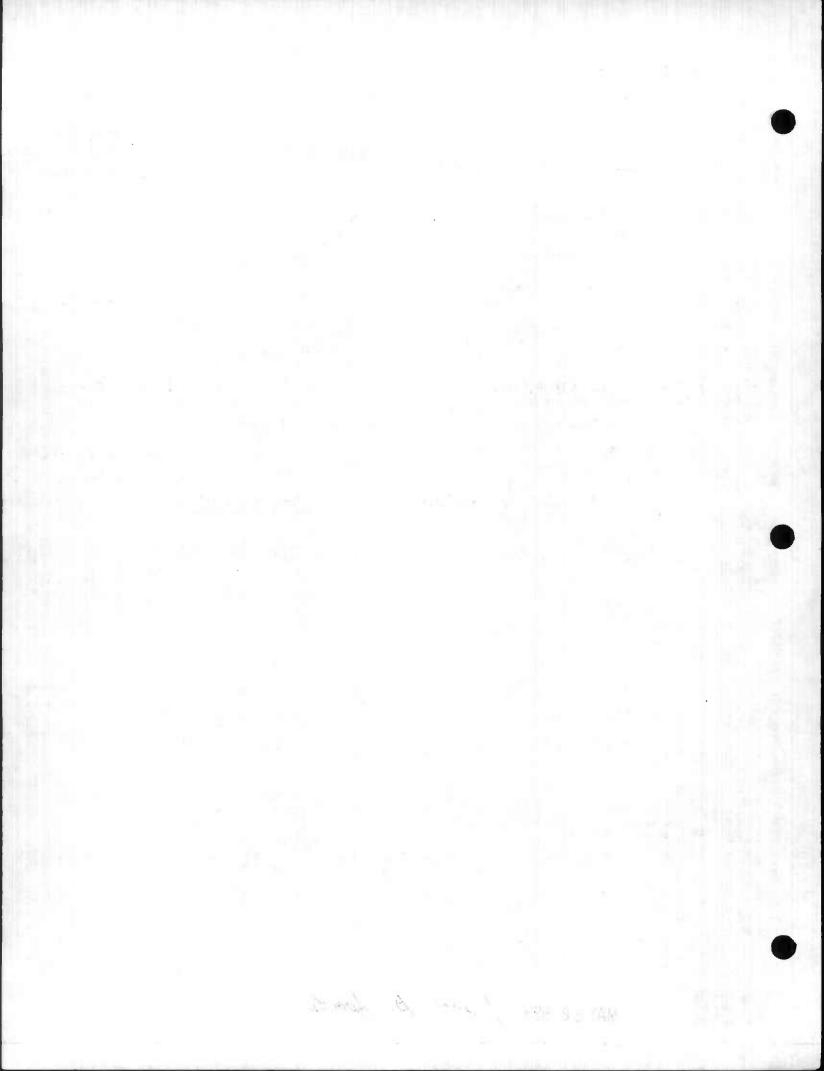
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KOMAL KDANG M.D., 3455, WILKENS AVE

D18362

MAY, 28, 1999

BALTO.



### Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death 25 May 1137Am Howard Marion Hayes 4b. City, Town, or Location of Death 4a Facility Neme (If not Institution, give street and number) 4c. County of Death Baltimore If Under 24 Hrs. 8. Da Mercy Stella Maris if Under 1 Year 6. Sex 1 Ø M 2 ☐ F 8. Date of Birth (Month, Day, Year) 07 08 39 9. Birthplece (Stete or Foreign Country) M • D • 5. Social Security Number 7. Age (In yrs. last birthday) Months Deys Hours Min Yrs. 59 215-46-5112 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 2930 Ellicott Driveway 21216 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes ② No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 Yes 2 XNo Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupetion (Giva kind of work dona during most of working life. DO NOT usa ratired) Elementery/Secondary (0-12) College (1-4or 5+) 12th grade Chemical Operator W.R. Grace Co. 17. Fether's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Maidan Sumama) Howard Hayes Viola Brown 19a. informant's Neme/Relationship (Typa, Print) 19b. Meiling Address (Straat and Number or Rural Route Numbar, City or Town, Stata, Zip Code) Delores Hayes-Wife 3319 West Rogers Ave, Baltimore Md 21216 20b. Place of Disposition (Nama of cematary, cramatory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from Stete 6/1/99 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park Randallstown, 22. Name end Address of Facility March F/H West 4300 Wabash AVe, Baltimore Md 21215 to that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Approximete Intervel Between Onset and Death heart tailure. List only one Immediate Cause (Final disease or condition resulting In deeth) Currer Due to (or es a consequence of): Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Diseese or injury that Initieted events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Wes an autopsy performed? 24b. Were autopsy findings eveilable prior to completion of cause of death? 1 ☐ Yes 2 ☐ No STELLA MARIS AT MERCY 25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Jother (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how initing occurred 27. Manner of Death

**Physician** /Medical **Examiner** Examiner

permit. Pages 1 end 2 Department of Health e Important: if item 27 is any injury or other trai page.

**Physician** 

/Medical

Examiner

Directo

Funeral

by

Completed

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**Funeral** 

**Director** 

item 27 is marked other than "natural", or frems 23a or 28a-f show other traumstic svent, the Madical Examiner must be notified at

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attending physician end for use as the bunai-tran USB BS 8 has

Physician/Medicai

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Completed

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Certification:

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certificate this funeral After

certificata be executed Division of Vital Records, Attending i or Attending sefter deeth.

29a. Certifie (Check only one)

1 Natural

Accident

3 Suicide

4 - Homicide

🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

5 Pending Investigetion 6 Could not be determined

28a. Date of injury (Month, Day Year) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28b. Time of

28c. Injury et Work?

1 Yes 2 No

Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29b.	Signature	and title	of cartifier
	> D	1人 (	had

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29c. License number D40854 29d. Date signed (Month, Day, Year) 5

21202

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print)

St Paul Pl Baltwer 301 Ruseber MO 31. Date filed (Month, Day, Year)

State Registrar

MAY 28 1999

32. Registrar's Signature

**DHMH 16 Rev 6/95** 

Hospitai 24 hours

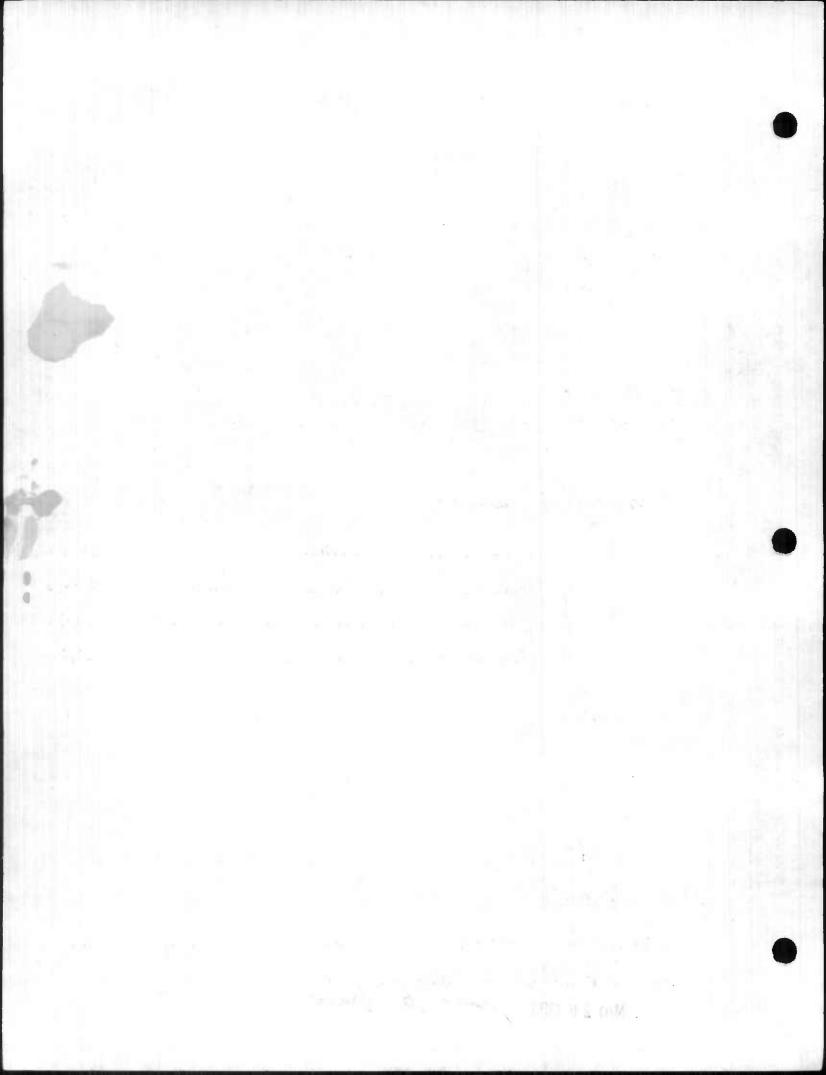
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	/Medica Examine	4a Facility Neme (If not institution, give street and number)  4b. City, Town							n, or Location of Death ORE CITY				
1	Funeral Director	5. Social Security Number 224-40-7671	6. Sex 1 X M 2 ☐ F		. last birthday) 2 Yrs.	Months Days		24 Hrs. Min.	8. Deta of Birth (Month, Dey July 6,	Year) 1936	Counti	rthplece (Stete or Foreign ountry) rginia	
the Maryland 28a-f show	or 28a-f show be notified at	Usuel Residence of Decedent 10a. Stete 10b. Cou Maryland 10e. Street and Number	nty		ity. Town or Lo				1	Og. Citizen of \		id. Inside City Limits 1 ▼ Yas 2 □ No	
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21215-0020	led within 72 ho bygleror. Ver than "natur It, the Medical.	15. Dece (Specify only hig Elementery/Secondary (0-1:		e (1-4or 5+)	(Give life.							- AGENT	
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Baltir	permit. P Departme Importan any Injur 2058.	4 Donetion 5 Nother (Specify)in state  21. Signature of Fureral Service Licensee  Ronald 9. Wade, Director State Anatomy Board, 655 W. Baltimere, MD 21201									lmore	Street	
	Physician /Medical	23a Par 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feliure. List only one cause on each line.  Appropriately. Onset										Approximete Intervel Between Onset and Deeth	
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,097	rsician and e bunal-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury		Due to (or as a consequence of):  thrombosis of left internal carotid								Sdays	
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ñ	death d for	Pert II. Other significant cond	Itions contributing to	death but not re-	sulting in the u	ndarlvina causa ni	iven in Pert t	-	23h. Did to	ohacco usa co	ntributa to	the cause of death?	
s, P.O	y th	Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert t.  23b. Did tobacc.  1 Yes										ably 4 Unknown	
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DIVISION	tal or Attending P rs after death. al Director: After t led in by the funer.  Certification:	2 Accident inve	ld not be 28e. Pla	One Disea of lawy. At home for street factors office					28f. Location (Street end Number or Rural Route Number, City or Town, Stele)				
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	To the Company of the	29b. Signetura and title of cert		ent physi	cian	29c. License number RES - DD0				29d. Data signed (Month, Day, Year) May 2, 1999			
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Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Items: 15,16a,b per F.H G-771 5/28/99 reb Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Dete of Death Month Day Yaar **Physician** Robert 21 MAY 1999 18:25 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CITY THE JOHNS HOPKINS HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Data of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral**  Birthpleca (Stata or Foraign Country) Days 10XM 20 F Director 229-10-2133 80 March 8, 1919 Georgia Usual Rasidance of Decedent the Maryland 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits show Md. Baltimore Catonsville 1 ☐ Yas 2 ☑ No Director 28s-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or death with USA 15 poplar avenue 21228 Funeral Rems : 12. Wes Decedent Ever in U,S. Armed Forcas? 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian than "netural", or item the Medical Examiner. Black, Whita, atc. filed within 72 hours after Hygiene. ther than "netural", or its 1 □XYas 2 □ No If Yas, Giva 1 Navar Married 2 Merried 21215-0020 1 ☐ Yas 2 ☐ XNo Specify: by Specify: White 3℃ Widowed 4 Divorced Year or Datas: Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Electrician Federal Government -Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Peges 1 and 2 should be fill ment of Heelth and Mentel Hant: If Item 27 is marked out Be Robert Lee Griffin, Sr. Emma Jennings 19a. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Bonita Lee Ouellette(Daughter) 3011 Hickorymede Dr. Ellicott City, Md. 21042 or other 20a. Mathod of Disposition 20b. Plece of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 Burlal 2 Cremetion 3 □Ramoval from Stata Department of important: If any injury or 5/22/99 Baltimore, Maryland Othar (Specify) Metro Crematory 4 Defration 22. Nama and Addrass of Facility 21. Sig Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Deeth **Physician** Immediata Causa (Finel disaase or condition resulting In daath) /Medical Examiner Examiner Abdomina corrac o Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last pue Due to (or es a consequence of) The law requires that the death certificate be axed Box 68760. Physician/Medical the Dua to (or as a consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 2 1 No 1 Yas 1 ☐ Yas 2 ☐ No this certificate Attanding Physician: 25. Was casa ratarred to medical axaminar? 28. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Medical Certification: To 1 Yas 20 No Inpatient 2 ER/Outpatiant 3 DOA 28a. Data of Injury (Month, Day Year) funeral 27 Mannar of Death 28b. Tima of Injury After t 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Pending invastigation 1 Natural 1 Yes 2 No 24 hours after death. Funeral Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At home, farm, streat, factory, office building, atc. (Specify) 4 - Homicide 6 29a. Cartifier 🔀 Certifying Physician: To tha best of my knowledga, deeth occurred at the time, date and place, end dua to the cause(s) and mannar as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data and placa, and due to the ceusa(s) and manner steted. within 2 To the 29b. Signature and title pf certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) RES-000 30. Nama and eddrass of person who completed causa of death (Item 23a) (Type, Print)

Registrar

**DHMH 16 Rev 6/95** 

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31. Dete filed (Month, Day, Year)

32. Registrar's Signatura

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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 3. Tima of Deeth 1. Decedent's Neme (First, Middle, Last) Month Yee William Eugene Goff May 1999 10:02 P.M. 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street end number) Prince Georges Hospital Cheverly Prince Georges If Under 1 Yeer 5. Sociel Security Number If Under 24 Hrs. Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Min 15 M 2 F Months Devs Hours 220 66 1301 Yrs. 41 Dec. 6, 1957 Maryland Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 635 - B Street 21122 U.S. 12. Wes Decadent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Maritel Stetus Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify 3 □ Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation 16b. Kind of Bustness/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) 11th Door Mechanic Carolina Door Controls 18. Mother's Neme (First, Middle, Meiden Surneme) 17. Father's Neme (First, Middle, Last) Ralph E. Goff Joan C. Martin 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. tnforment's Neme/Reletionship (Type, Print) Vicki Goff wife 635 - B Street Pasadena, Maryland 21122 20a. Method of Disposition 20b. Ptece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 Buriel 2 □ Cremetion 3 □ Removel from State Glen Haven Memorial Park 5/6/99 4 ☐ Donetion 5 ☐ Other (Specify) Glen Burnie, Maryland 21. Signeture of Funeral Servica Licensee 22. Name end Address of Fecility Gonce Funeral Home P.A secome manuouren 4001 Ritchie Highway Baltimore, Md. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Immediate Ceuse (Finel disease or condition resulting to deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Pert II. Other significant conditions 23b. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying ceuse given in Pert I. 1 ☐ Yes 2 ☐ No 3 Probably Unknown 24b. Were autopsy findings evaitable prior to completion of cause of deeth? 24e. Wes an autopsy performed? 2 No 1 □ Yes 2 □ No (Month. Dev Year) Work? PRIVER OF MOTORCYCLE VS injury 5 Pending

end I-transit requires that the death certificate be executed physician er s the burial-t P.O. Box 68760, 80 980 been signed by the should be detached Records, ₩0 page 2 The certificate Division of Vital Hospital or Attending Physician: director Certification: To this funeral After deeth. Ofrector: To the Hospital or A within 24 hours efter To the Funeral Dire completely filled in b

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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traumatic event, the Medical

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Lepartment of Heelth an Important: If frem 27 is meny Injury or other 2006.

**Physician** /Medical

Examiner

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Pages 1 and 2 should be nent of Heelth and Mental

Baltimore, Maryland 21215-0020

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miner? Yes 2□ No	Hospitel: 1 Anpatient	2 ER/Outpetient	3□ DOA	Other: 4 Nur	rsing Home	5 Residence	6 Other (Spec				
nner of Deeth	28e. Dete of Injury	28b. Time of	28c.	Injury et	28d.	Describe how Ini	ury occurred				

1 Naturel
2 Accident investigation 04-30-99 6 Could not be determined 3 Suicide

1 Yes 2 No 1605 Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

AUTO COLLISION

Location (Street and Number or Rural Route Number, City or Town, Stete) WEST STREET & PAVIS ST ANNAFOLIS

STREET 29a. Certifier (Check only one)

Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

29b. Signeture end title of certifie

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar 31. Dete filed (Month, Day, Year) 32 Registrer's MAY 2 8 1999

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Ma V 1999ar 3:25AM John F. Gallagher, Sr. 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Howard Howard County General Hospital If Under 1 Year | If Under 24 Hrs. 8 5. Social Security Number 7. Aga (In yrs. last birthday) Data of Birth (Month, Day, Year) Birthplaca (State or Foraign Country) Days 1⊠M 2□ F 033-01-2244 Yrs. March 27,1916 MASS **Usual Residence of Decedent** 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No MD Prince George **Beltsville** 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11512 Nevis Drive 20705 U.S.A. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Rece - American Indien, Black, Whita, etc. 12. Was Decedent Evar in U,S. Armed Forces? 1 ⊠ Yas 2 □ No If Yas, Giva Year or Datas: 1 Never Married 2 Married WWII Specify: White 1 ☐ Yes 2 ☑ No Specify: 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondery (0-12) Physicist F.B.I. 17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Meiden Surnama) Bessie Murtagh Patrick Gallagher 19a. Informent's Name/Ratationship (Type, Print) 19b. Meiting Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Mary C. Dieringer Daughter 11206 McGee Way, Ellicott City, Maryland 21042 20b. Plece of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stata 5/28/99 Clarksville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Columbia Memorial Park 21. Signature of Funaral Service Licensee 22. Nama and Addrass of Facility Witzke Funeral Homes. Inc. 1630 Edmondson Avenue, Catonsville, Maryland 21228 Lemmer 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarvat Batween Onset and Death Immediete Causa (Final disease or condition resulting in death) 2 months Aspiration Pneumonia Dua to (or as a consequence of): 4 months Cerebrovascular Accident Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Complete Heart Block 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yas 2 No 1 ☐ Yas 2 No 25. Was case refarred to medical 26. Placa of Death (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 8 Other (Specify) 1 Yes 2√ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNaturat 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be detarmined 3 Suicide 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide

The lew requires that the death cartificate be executed Records, P.O. Box 68760. apital or Attending Physicien: The hours efter death.
Inexal Director: After this certificate y filled in by the funeral director, pt of Vital Division

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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permit. Pages 1 and 2 should be flied within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural", or lies any fnjury or other traumatic event, the Medical Examina

**Physician** 

/Medica

Examiner

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Saltimore, Maryland 21215-0020

Director

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Physician/Medical Examiner

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Certification: To

Medical

29a. Certifier

29b. Signature, and fitt

State Registrar

**DHMH 16 Rev 6/95** 

24 hours Hospital To the Hosp within 24 hou To the Funer completely fil

> Salway, Μ. 31. Data filed (Month, Day, Year) MAY 2 8 1999

ayno 30. Nama and address of person who completed cause of death (ttem 23a) (Type, Print)

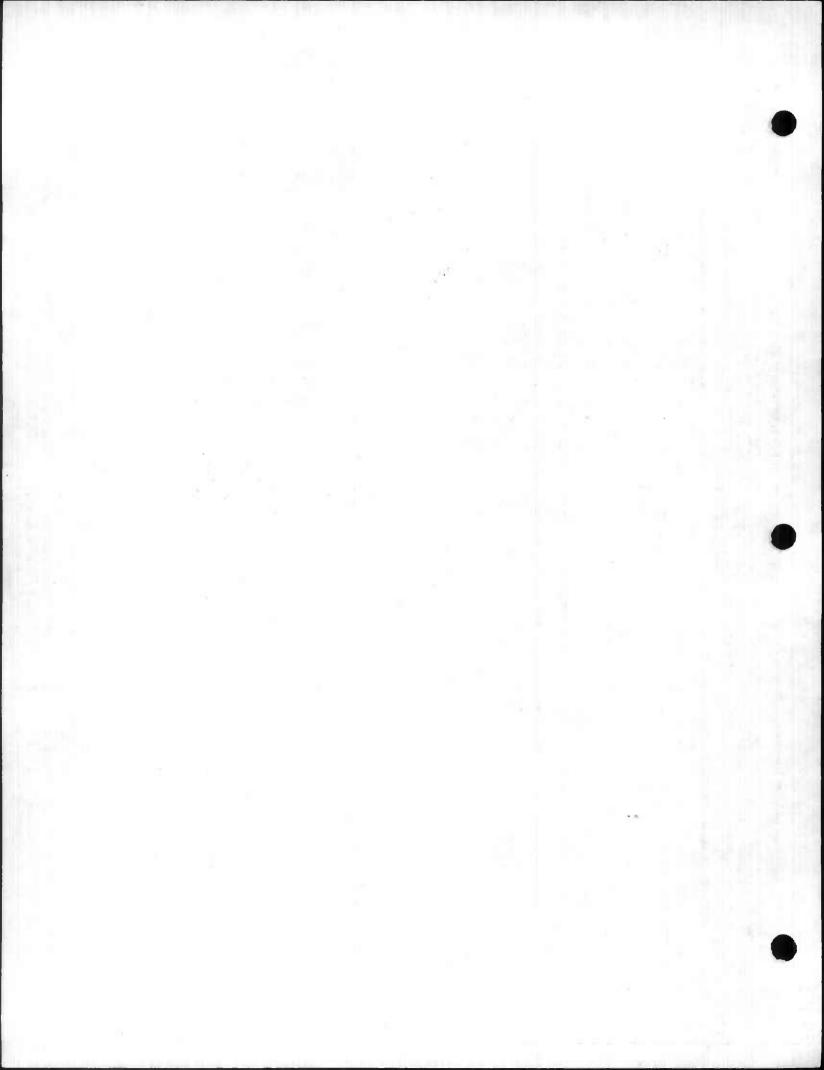
M.D. 2 Knoll North Columbia, MD 21045
82. Hegistrar's Signature

B. Sparker

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and mannar es stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) MAY, 27, 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ITEM: #10B PER F.H. G771 5-28-99 WR. Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Day Yas **Physician** HARVEY 24 GREENBERG MAY 1999 5:30PM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1 GRISTMILLL CT., APT. 207 BALTIMORE BALTIMORE 7. Age (In yrs. last birthday). 70 Yrs. If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex If Under 1 Year 6. Data of Birth (Month, Day, Year) 9. Birthplace (Stata or Foreign **Funeral** Months Days MM 20 F Director OCT 18, 1928 MARYLAND **219-**22**-**1234 10a. Stata 10b. County BALTIMORE 10c. City, Town or Location 10d. Insida City Limits must be notified at MD DALTIMIORE BALTIMORE 1 ☐ Yas 2X No Director 288-7 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 21208 USA 1 GRISTMILL CT., APT. 207 Norms 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 12. Was Decedent Evar in U,S. Armed Forcas? 14. Race - Amarican Indian, Black, Whita, atc. Yas 2 No NYas, Giva Year or Datas: filed within 72 hours after 1 Nevar Married 2 Married 8 Baltimore, Maryland 21215-0020 1 ☐ Yes 3 ☐ No Specify: Specify: WHITE à 3 Widowed 4 Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Hygione. Elamantary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w
Department of Health and Mental Hygien,
Important: if Iben 27 is marked other tha
any Injury or other traumatic PHARMACIST PHARMACEUTICAL 17. Fathar's Nama (First, Middla, Last) 16. Mothar's Nama (First, Middla, Maidan Surname) 96 **JENNY** CHESLOW GREENBERG ALBERT 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 1 GRISTMILL CT., APT. 207 MRS. ANSELA GREENBERG (WIFE) BALTO., MD 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata 1 Burial 2 □ Cremation 3 □ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) OHEB SHALOM MEM. PARK 5/26/99 REISTERSTOWN, MD 21. Signature of Funaral Sarvice Licen 22. Nama and Addrass of Facility
SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** 12 years /Medical Immediata Causa (Final Stomach CATCINOMA diseasa or condition rasulting in daath) Examiner Dua to (or as a consequence of) Examine iclan and burial-transit that the death certificate be executed Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequence of): physician the burial Box 68760. Physician/Medicai Dua to (or as a consequence of): 88 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown V18708 signed b Records, þ Completed 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of cause of death? page 2 s 2 1 No 1 ☐ Yas 1 ☐ Yas 2 ☐ No Division of Vital 25. Was casa rafarred to medical axaminar? Be 26. Place of Death (Check only ona) Hospital: Other: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 1 Yas 2 No Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA siq 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 Pending invastigation n 24 hours after death, le Funeral Director: After pletely filled in by the fur 1 Yas 2 No 2 Accident 6 Could not be detarmined 26f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicide. 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicie Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. edical 29a. Certifie To the Hosp within 24 hos To the Fune completely fi (Check only one) 29b. Signature and title of contribe 29d. Data signed (Month, Day, Year) who completed fause of death (Item 23a) (Type, Print) 30. Name and addrass of pe 600 Styn walters 21133

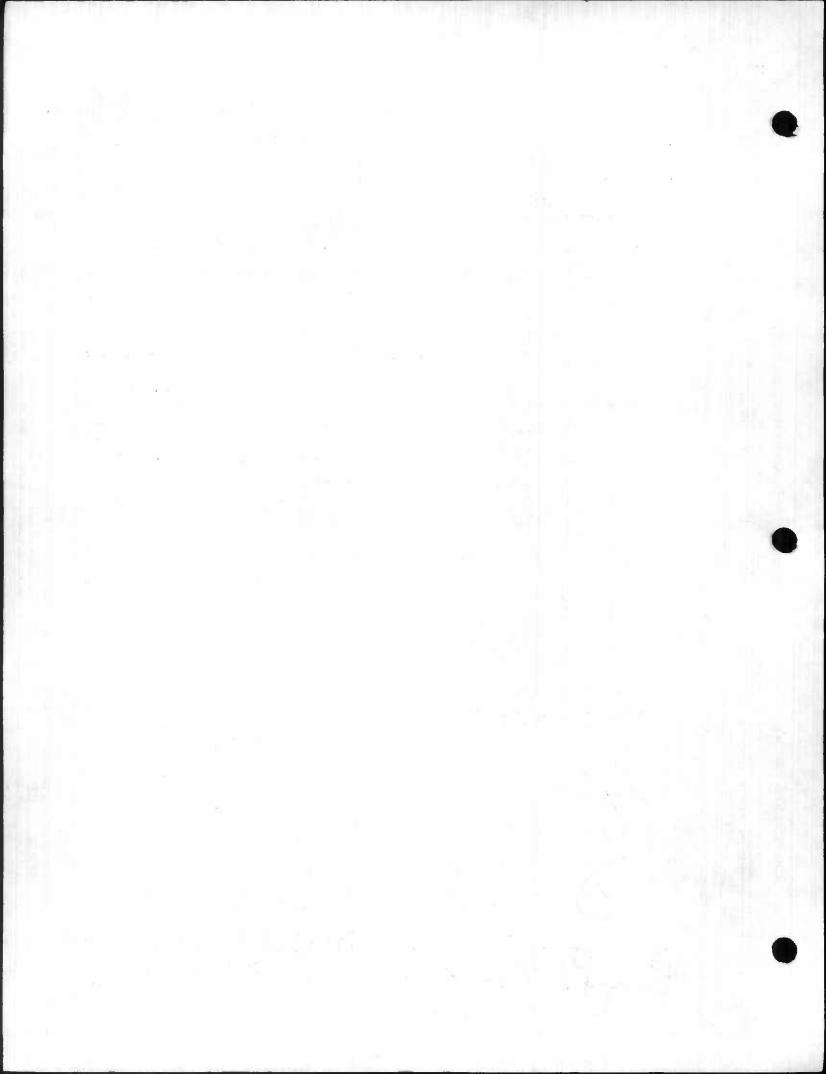
State Registrar DHMH 16 Rev 6/95

MAY 2 8 1999

31. Data filed (Monty, Day, Year)

**ORIGINAL** 

32. Registrar's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dovie Malinda Houghtling 05 12:15 am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1045 Hemlock Lane, Apt. 1 Westminster Carroll If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) if Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Days Months 1 □ M 20 F 217-76-0559 Director 38 Oct. 29, 1960 Maryland Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with the Maryland nent of Health and Mentel Hygiena. Instural, or items 23a or 28a-f show int: if item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location al Hygiena. I other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1045 Hemlock Lane, Apt. 1 21157 Funeral U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decadent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. I ☐ Yes 2 ☑ No It Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No þ Specify: Specify: white 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind ot Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own home traumatic evant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Walter Franklin Dunford Sr. Mary Ellen Vickers 19a. Intormant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ant of Health a t: if Itam 27 is y or other trac Mary Dunford/mother 3613 Milford Mill Rd., Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department important: if any injury or 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licansee 22. Name and Address of Facility Wade, Director Ronald S. State Anatomy Board, 655 W. Baltimore Street nuu Baltimore, MD 21201 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical tmmediate Cause (Final disease or condition resulting in death) **Examiner** Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effect death.

To the Funeral Director: After this certificate has been signed by the attending physician and completaly filled in by the funeral director, page 2 should be detected for use as the burnal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, signed by the attending physiclan d be deteched for use es the buris Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Dtd tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown þ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐NO 1 ☐ Yes 2 ☐ Ne Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Settifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar

31. Date filed (Month, Day, Year) MAY 2 8 1999

Flavio W. Kruter,

29b. Signature a

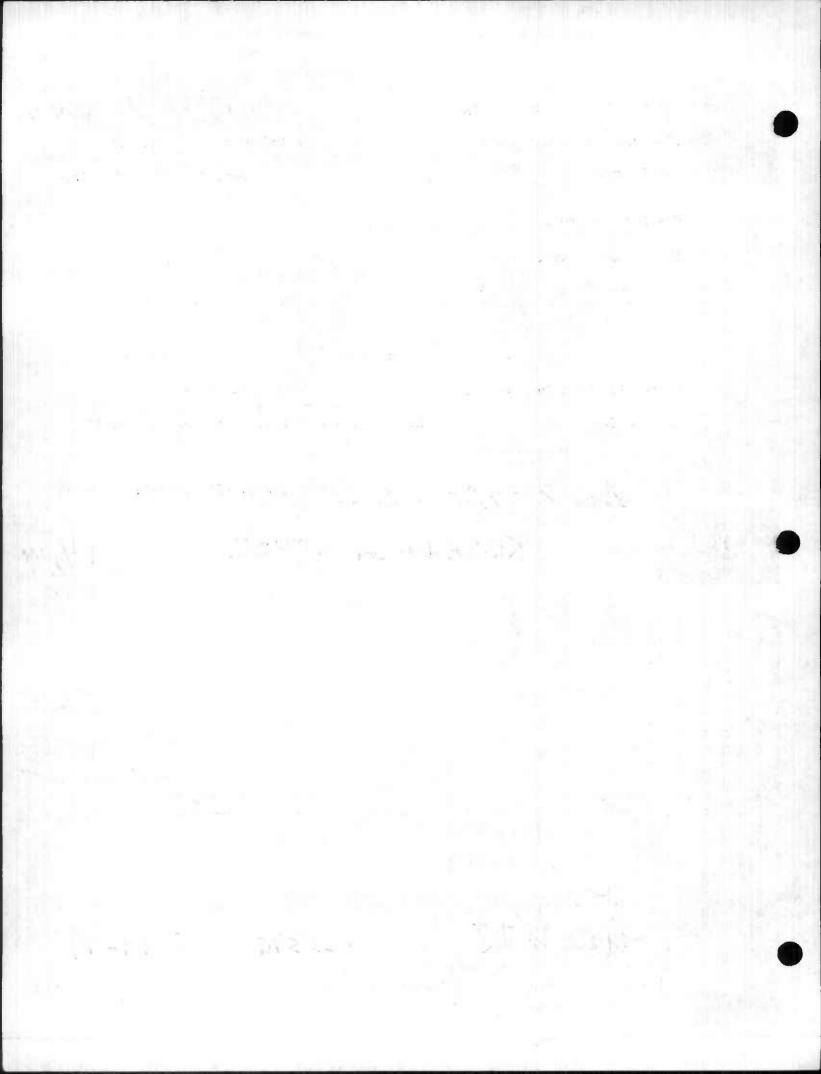
32. Registrar's Signature

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

M.D. - 224 Wash, Hots. Med. Ctr. - Westminster, MD 21157

29c. License number 03/398

29d. Date signed (Month, Day, Year)



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month 25, 1999 11:2080 Kobert Harris May 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Rehabilitation and Extended Thre Baltimore Baltimore 7. Age (In yrs. lest birthdey) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth
Months Devs Hours Min. (Month, Dey, Year) 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) 10XM 2□ F Yrs 212 20 2465 VA. Usual Residence of Deceden 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MD. BALTIMORE **EDGEMERE** ¥☐ Yes 2☐ No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 7209 ORTH RD 21219 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 (2) Yes 2 □ No If Yes, Give Year or Detes: WW] 11. Meritel Stetus Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 XNo Specify: Specify:BLACK 3 ☐ Widowed 4 ☐ Divorced WWII 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Dacedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) DELIVERY FURNITURE 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) ARTHUR HARRIS ROSA UNK 19e. tnforment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CLARISSA M. HARRIS/WIFE 7209 ORTH RD. BALTO., MD. 21219 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete Denetion 5 Other (Specify) GARRISON FOREST VET CEM 6/2/99 OWINGS MILLS, MD. of Funerel Service Licansee 21. Signatu 22. Neme end Address of Fectility JAMES A. MORTON & SONS FUNERAL HOMES, INC 1701 LAURENS ST. BALTO., MD. 21217 0 23a. Pert I Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or hear failure. List only one cause on each line. Approximete Interval Between Onset and Death immediete Causa (Finei Alzheimer's type disease or condition resulting in deeth) Sequentielly tist conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaese or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Due to (or es e consequenca of) Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24a. Was an eutopsy performed? 24b. Were autopsy findings available prior to completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 12 No 25. Wes case referred to medical 26. Plece of Death (Check only one) Other: 4 Proving Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Panding trivastigation 1 WNatural 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 ☐ Homicide

1 Certifying Physictan: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete and place, and due to the cause(s) end menner stated.

29c. License number

D0032548

29d. Dete signed (Month, Day, Year)

Box 68760. Division of Vital Records, P.O.

attending physician end for use es the burial-transit been signed by the should be detached After this cartificate has the Hospital or Attending Physician: To the Hospital or Attending within 24 hours efter death.
To the Funeral Director: Afte completely filled in by the fun-

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

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Director

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r than "natural", or thema 23a or 28a-f ahov the Medical Examiner must be notified at

pemit. Pages 1 and 2 should be filled within 72 hours after to Department of Heelin and Mental Hygiene. Important: If them 27 is marked other than "natural", or then any injury or other traumatic auch.

**Physician** /Medical

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Certification:

29e. Certifier (Check only one)

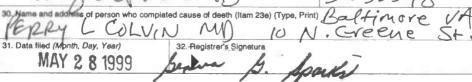
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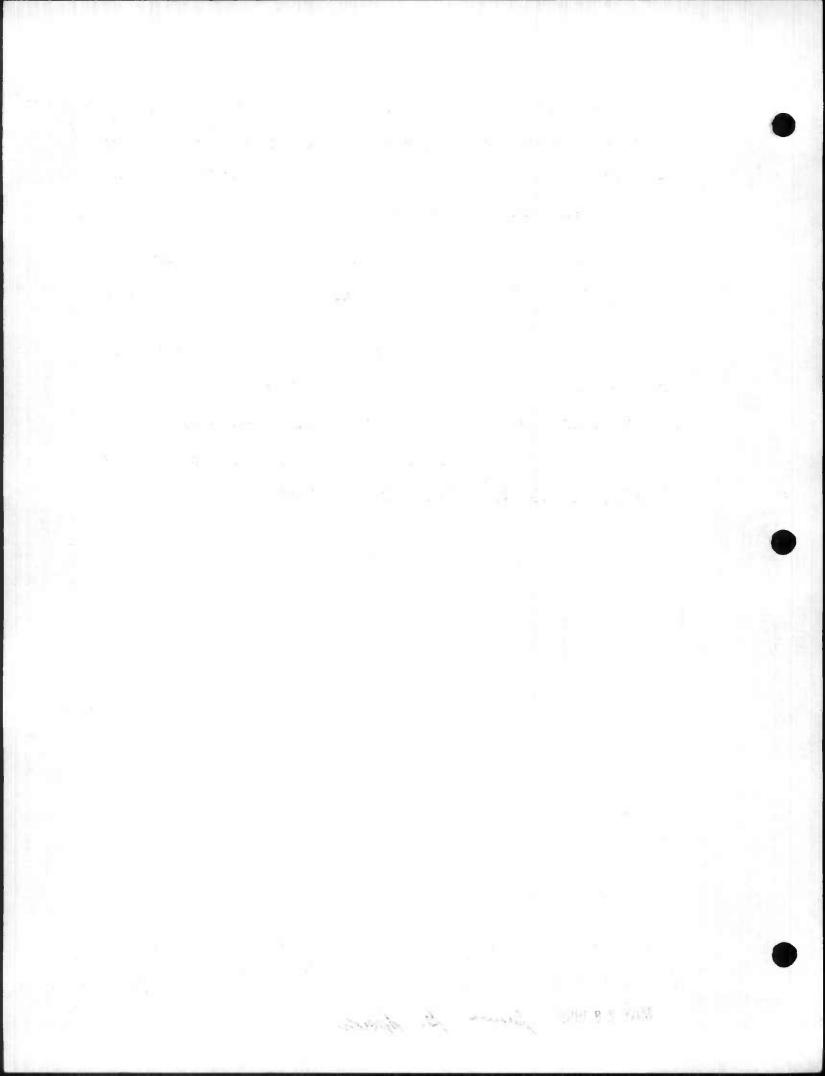
State Registrar

31. Data filed (Month, Day, Year) MAY 2 8 1999

29b. Signeture end title of sprtifier



**DHMH 16 Rav 6/95** 



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Yea EDDIE HARMON 1999 5:50 AM MAY 27 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE N/A HARBOR HOSPITAL CENTER If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) Days Months 1 M 200 F 247 36 9715 73 March 3, 1926 South Carolina Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Anne Arundel Baltimore 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5327 Wasena Avenue 21225 U.S. 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status ☐ Yes 2] No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3€ Widowed 4 Divorced White Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Eiementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12th 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) Lula Presley Edward Dill 19a. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Harmon 465 Palmer Terrace Westminster, Maryland 21158 20b. Place of Disposition (Neme of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, cremetory or other place; 1X Buriel 2 ☐ Cremation 3 ☐ Removal from State 5/29/99 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Cedar Hill Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway ramerouski Baltimore, Md. 21225 cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Finel CANCER LUNG MONTHS disease or condition resulting in death) Due to (or as e consequence ot) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence ot) Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the causs of death? 1 Nos 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performedi 1 Yes 2 NO 1 ☐ Yes 2 ☐ No 25. Was case reterred to medica 26. Place of Death (Check only one) examiner Hospitei: 1 (Stripatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 THO 2 ER/Outpatient 3 DOA Date of Injury (Month, Dey Year) 28c. Injury et Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, term, street, tactory, office building, etc. (Specify) 4 Homicide

P.O. Box 68760, certificate be Records, Division of Vital

signed by certificate Attending Physician: this After A Hospital or Attention 24 hours after deeth.

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page 2

funeral

**Physician** 

/Medical

**Examiner** 

Directo

Funeral

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Completed

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**Funeral** 

Director

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Examiner

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Physician/Medical

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29e. Certifier

(Check only one)

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Maryland 21215-0020

altimore,

State Registrar

SANGEETHA 31. Dete tiled (Month, Dey, Yeer)

29b. Signature end title of certifier

30. Name end eddress of person who completed cause of death (item 23e) (Type, Print) MURTHY

32. Registrar's Signature

HOUSE

OFFICER

3001, S. HANOVER STREET ,

1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

P10647

29d. Date signed (Month, Dey, Year)

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BALTIMORE

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MD 21225

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Audrey Morrison Holdefer May 26, 1999 2:00 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10 Bandon Court 102 Timonium

If Under 24 Hrs. Baltimore If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday)
7.3 vrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. 1 M 2 F Months Hours Yrs. 220-24-5564 **Director** DE. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland near of Health and Mentall Hyglone. mit: If them 27 is merited other than "patural", or items 23s or 28s-f show ury or other traumatic event, the Health Engineer must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director MD. Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 10 Bandon Court 21093 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indien Black, White, etc. 1 ☐ Never Married 2 ☐ Married 21215-0020 1 Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry Stifler Margaret Morrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George W. Holdefer (husband) 10 Bandon Court 102 Timonium, MD, 21093 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, Stete Department of H Important: If Its any injury or of pncs. 1 ☐ Burial 2 🖺 Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 5/27/99 Towson, MD, 21. Speature of Funeral Service Licensee Dermis C. Carroll 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 23a. Part1. Enter the diseasa, or complications that caused the death. Do not entar tha mode of dying, such as cardiac or respiratory arrest, shock, or beart failura. List only one cause on each line. Approximata **Physician** Immediata Causa (Final disease or condition resulting In death) /Medical 5 months I way sances Examiner Due to (or as a consequence of): Examiner use as the burial-transit The law requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical Due to (or es e consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown Division of Vital Records, Completed by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 certificate has 1 Yas 2 No 1 Yes 2 No or Attending Physician: director. 25. Was casa referred to medical examiner? Be 26. Place of Death (Check only ona) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Pasidence 6 Other (Specify) Medicai Certification: To 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation s after death.

J Director: Aft

d in by the fu 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide To the Hospital o within 24 hours af To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

**DHMH 16 Rev 6/95** 

Day, Year) 32. Registrar Signature

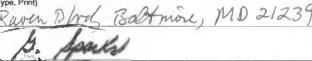
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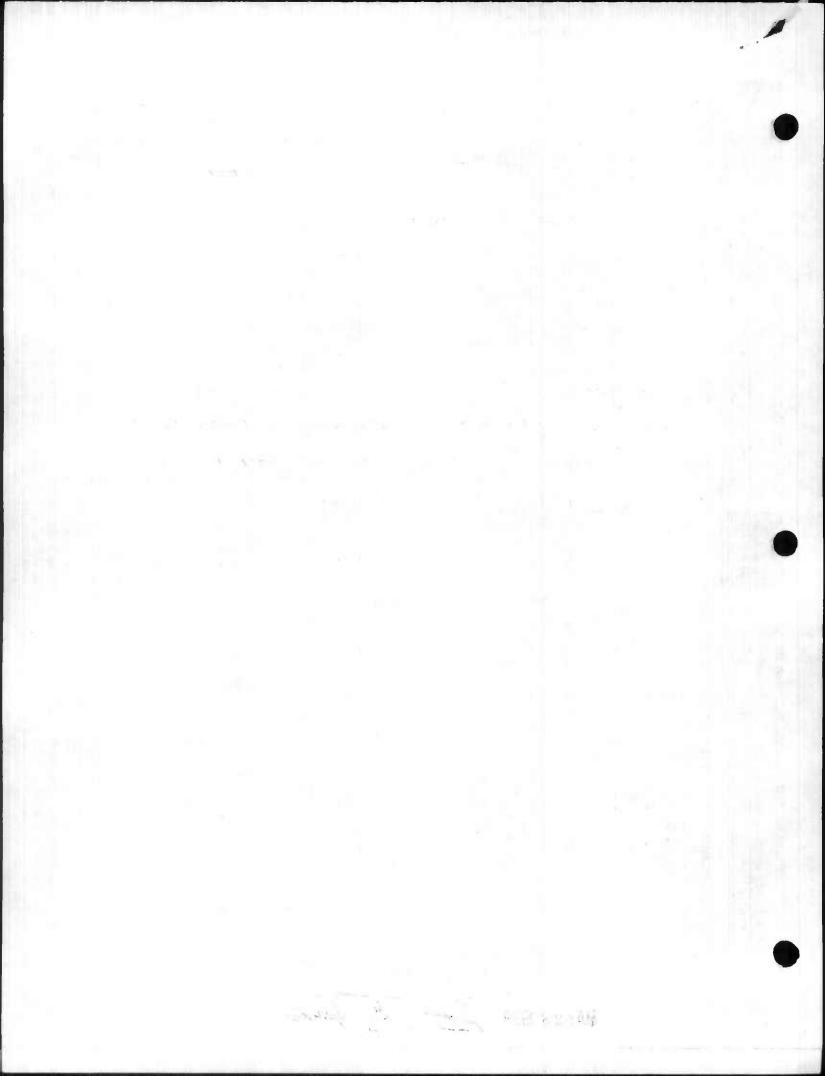
30 Nama and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Nama (First Middle Last) 2. Dete of Deeth HARRIS **Physician** THERESA 7:18 A.M 26 5 /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, giva street end number) 4c. County of Death Examiner MARYland OF Balt Balt. UNIVERSITY If Under 24 Hrs. 7. Age (In yrs. last birthdey). if Under 1 Year 5. Sociel Security Number 6. Sex Birthplece (State or Foreign Country) **Funeral** Deys 1□ M 20XF Months Hours 213-28-4503 JULY 28, 1925 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Meniel Hygiene.
Important: If item 27 is marked other than "naturel", or items 23a or 28s-4 show any injury or other traumatic avent, the Medical Examiner must be notified at 10a. Stete 10b. County 10c. City. Town or Location 10d. fnsida City Limits N/A Maryland 1 Yes 2 □ No Baltimore Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1548 Kirkwood Road 21207 USA Funeral 12. Wes Decedent Evar in U,S.
Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American indien, Black, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 3 ☐ No Specify: Specify: White þ 3 ☐ Widowed 4 ※ Divorced Year or Datas: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Domestic 12 18. Mother's Name (First, Middle, Melden Sumeme) 17. Fether's Neme (First, Middle, Last) Albert G. Karcher Mary J. Bertuman 19e. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Henry Al Heffler, Sr. / friend 1548 Kirkwood Road Baltimore, MD 21207 20b. Plece of Disposition (Neme of cemetery, cremetery or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Data 1 Burlel 2 Cremetion 3 Removel from Stata Metro Crematory, Inc. 5/28/99 Baltimore, MD 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama end Addrass of Fecility
Cremation Society of Maryland, 21. Signatury of Funeral Service Licensee McDonald F. lisee 299 Frederick Road Dawn Baltimore, MD 21228 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onsat and Death **Physician** /Medical immediate Ceuse (Final disaasa or condition resulting in deeth) Examiner Examiner maestive physician and s the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initieted events rasulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of) signed by the e Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to complation of cause of deeth? been si Completed 24e. Wes en eutopsy performed? is certificate has director, page 2 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: Be 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After s effer des. 1 Neture! 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined To the Hospital or Atte within 24 hours effer der To the Funeral Directo completely filled in by the 3 Suicide 28e. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) and menner es stated.

2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) and mannar stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifiar 29c. Licensa number Kolwel M.D. Michael a 1)43196 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MICHAEL A. ROLNICK - U. OF Mayland MICHAel - UNIV\_

State Registrar 31. Dete filed (Month, Dey, Year)

32. Registrar's Signeture

MAY 28 1999

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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Deeth 6:30 An Louella Mae Holland 26 4c. County of Deeth 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth Worcester Atlantic Gen. Hospital If Under 1 Yeer if Under 24 Hrs. 8. Date of Birth (Month, Day, Y Aug. 24 9. Birthplace (State or Foreign County) Mary Land 5. Social Security Number 7. Age (In yrs. lest birthday) . 1913 Months Deys Hours 1 M 2 F 212-05-0271 85 Yrs Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Berlin Maryland Worcester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21811 12592 Eagles Nest Rd. U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Giva Yeer or Dates: 14. Rece - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Merried 1□ Yes 2□No Specify: Specify: White 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Operator Telephone Co. 17. Fether's Neme (First, Middle, Last) 18. Mothar's Neme (First, Middle, Maiden Sumame) Emma Baublitz Harry Martin 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stata, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 12592 Eagles Nest Rd. Berlin, Md. 21811 Lois Ruby - daughter 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 Buriel 2 Cremation 3 Remove from State May 28, 1999 Pikesville, Md. Druid Ridge Cem. 4 ☐ Donalion 5 ☐ Other (Specify) 21. Signeture of Funeral Service License 22. Name and Address of Fecility Eckhardt Funeral Chapel Dott 11605 Reisterstown Rd. Owings Mills, Md. 21117 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haer failure. List only one cause on each line. Approximata Interval Between Onset and Deeth accident Cerebroviscolir Immediate Cause (Final disease or condition resulting in death) Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Causa (Disaese or injury that initieted events resulting in deelh) Last Due to (or es e consequenca of) Due to (or es e consequença of) 23b. Did tobacco uea contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown 24b. Wara eutopsy findings aveileble prior to completion of cause of daath? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Deta of Injury (Month, Dey Year) 28c. Injury et Work? 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred 1 PNatural 5 Pending

Examiner the 88 esn director, page 2 should be detect Holland, LovellA After this funeral

Hospital or Attending Physician: deeth. ofter deetl Director: 24 hours To the Hosp within 24 ho To the Fune completely f

**Physician** 

/Medical

Examiner

Directo

Funeral

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Completed

**Funeral** 

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumetic event, the Medical Examinar must be notified at

permit. Pages 1 end 2 should be filed within 72 hours after. Department of Health end Mental Hygiene. Important: if item 27 is merked other than "natural", or ther eny Injury or other traumatic event. the Mental Experimen

**Physician** 

/Medical

Examiner

Physician/Medical

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Completed

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Certification:

edical

altimore, Maryland 21215-0020

with the Maryland

death

State Registrar DhysIC12

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 Madical Examinar: On the basis of examination end/or invastigation, in my opinion, deeth occurred et the time, dete end pleca, end due to the cause(s) end menner steted. 29c. License number

1 Certifying Phyeician: To tha best of my knowledga, death occurred at the lime, date end place, end due to the cause(s) end menner es steted.

29d. Date signed (Month, Dey, Year)

29b. Signeture end little of certifier

MAY 28 1935

investigation

6 Could not be datermined

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30. Name and eddrass of parson who completed causa of death (Itam 23a) (Type, Print) DIKIN 9733 Healthwin Robert

Berle, M, Drive

28f. Location (Street and Number or Rural Route Number, City or Town, State)

31. Date filed (Month, Day, Year)

2 Accident

4 Homicide

(Check only one)

3 ☐ Suicide

29e. Certifier

32. Registrar's Signeture



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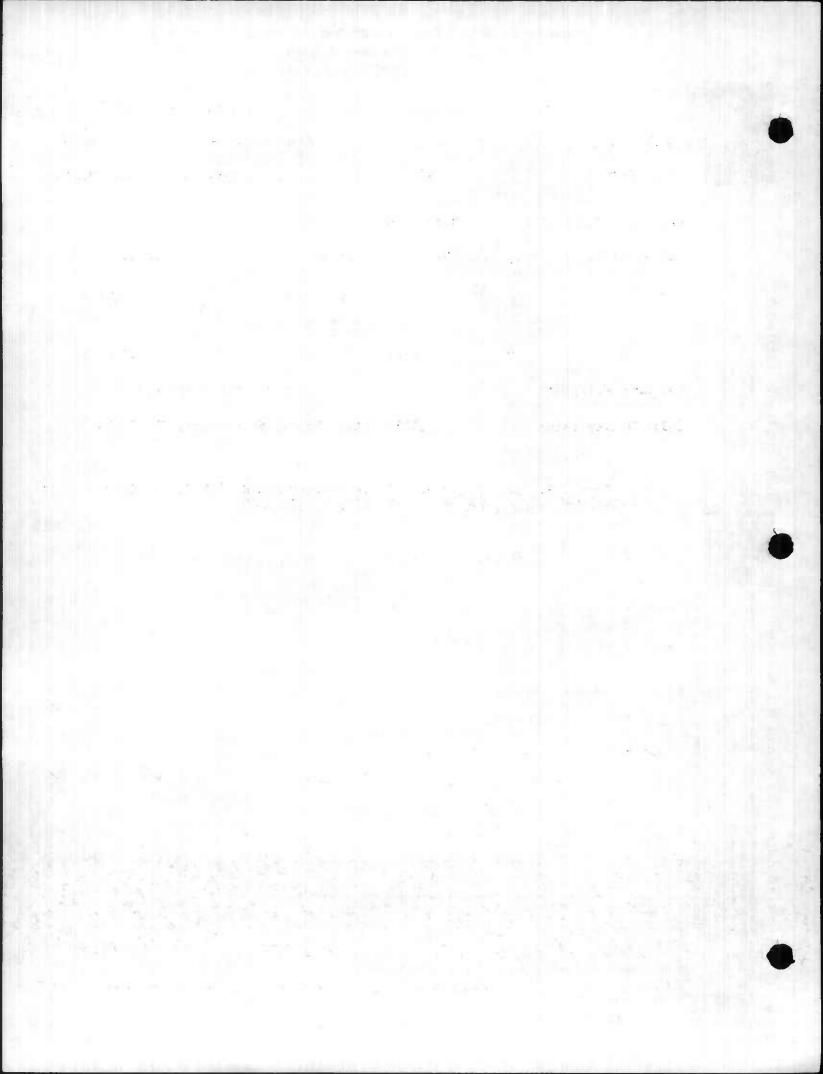
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	dical	ETHEL AUGUSTA JOHNSON  4e Facility Name (If not institution, give street and number)					4b. City, Town, or I	ocation of Deeth	14 Coun	ty of Death	04.37	
Exa	niner	WASHNETON					HAGEIS				670~	
Fune	ral .	5. Sociel Security Number		7. Age (In yrs. le	st birthdey)	If Under 1 Yea	ar If Under 24 Hrs.				place (State or Foreigntry)	
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erylend		Usual Residence of Decedent  10a. Stete 10b. County 10c. City, Town or Location								1	0d. Inside City Limits	
the Men 28a-f sh	ctor	Maryland Wash:	n					1 ☐ Yes 2 No				
き or 5	Directo	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cour	ntry?	
th w		55 E. Washing	ton St., A	pt. 507		2174	40		U.S.	Α.		
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	BeC	17. Father's Name (First, Middle	, Last)	· ·			18. Mother's Nan	ne (First, Middle,	Meiden Suma	me)	a)	
should be and Mental marked o	0	Benjamin M. Ep	pard				Laura A	ugusta	Seckman	n		
Maryland d 2 should be file th end Mental Hy 7 is marked othe traumatic evant		19a. Informant's Name/Relation	ship (Type, Print)		19b. Malii	ng Address (Stre	et end Number or Ru	iral Route Numbe	er, City or Tow	n, Stete, Zip	Code)	
CTOL		Julia Weaver/ne	eice		22015	Ottawa	Drive, Sn	ithsbur	g, MD	21783		
Baltimore, semit. Peges 1 en Depertment of Heal montant: If item 2		20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other (		00	ace of Dispo metery, crer	esition (Name of metory or other p	vlace)	Date	20c. Location	- City or To	own, State	
Baltimo permit. Pege Depertment of Important: If any Injury or		21. Signature of Faheral Service			22	2. Neme end Add	iress of Fecility					
Balt permit. Depend	g	Ronald S. Wade, Director State Anatomy Board, 655 W. Baltimore Str										
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		3/100 g	E Haut	Sme.		DS	1395		5/1	4/19	99	
•		30. Name and address of person	who completed caus	se of death (Item	23а) (Туре,	Print)						

State Registrar MAY 2 8 1999

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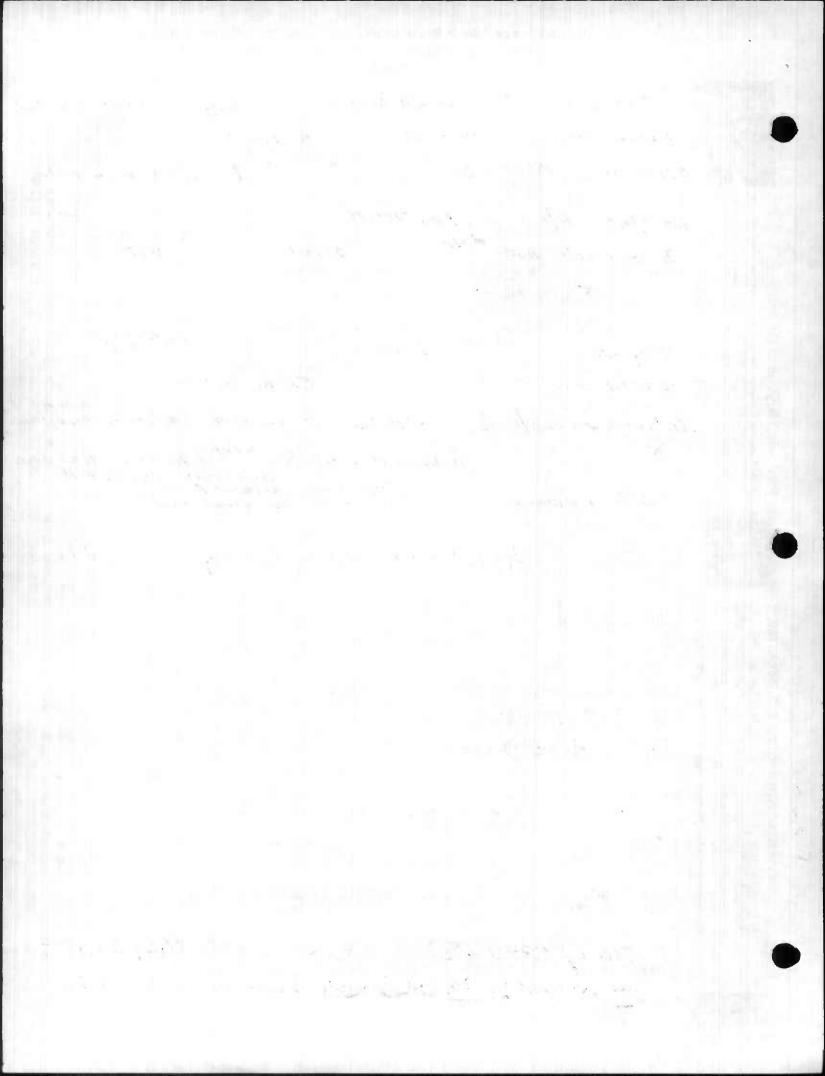


Please Type or Print in Black Indeible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** EdWARD JACKSON, SR. THEODORG 5:04 AM 1999 MAS /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital MUION HEMOLIAL BALTIMOLG If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 6. Sex M 2□ F **Funeral** Deys 6, 1937 NEW YORK 219-32-9136 Director Usuel Residence of Decedent Peges 1 and 2 should be filed within 72 hours effer death with the Maryland sent of Health and Mental Hygiene. 10c City Town or Location r 28a-f show 10a State 10h Count 10d. inside City Limits BALTAMORE 1 Nos 2 No Marylow Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 20 W. North 21201 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 ☐ No If Yes, Give Year or Dates: 7 is marked other than "naturel", or items traumatic event, tra Modical Examiner ma Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Marital Status Black, White, etc. 1 Never Married → Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify Black by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry BEHLIchem Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. LABOTER 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter SACKSUM SARAH WRIGHT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/2/ 3749 REISTERSTULL RUMO nt of Health a : If Item 27 is or other tra BAIHMOR, Marylows CatheRINE Inckson / WITE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 9 ARBUTUS, Marylmo Burial 2 Cremetion 3 Removal from State ARBUTUS Monorial fork 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CHATMAN - HARRIS F. H 240 Relsterstown Rums 21. Signature of Funeral Service Licenses 23e. Pert Enter the disease, or complications that ceused the death. Do not enter the mode of dyling, such as cerdiac or respiratory arrest, shock, or heer fellure. List only one ceuse on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final 24 hours GASTROINTESTING Bleeding disease or condition resulting in death) Examiner Examiner physician and the buriel-transit Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai Due to (or es e consequence of) Theodore Jackson Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contributs to the causa of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown VArices þ 24b. Were autopsy tindings available prior to completion of cause of deeth? Completed 24a. Was an autopsy Peptic VICER Disease 1 Yes 2 No 1 Ves 2 PNC Be 25. Was cese referred to medicel examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Yeer) 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homlcide To the Hospital o within 24 hours af To the Funerel D completely filled I 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(a) and menner as stated.

2 Madical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. edical 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name end address of pen 31. Date filed (Month, Day, Year) Parkway, Baltimore, Maryland 21218 East University

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State Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year May 6:00 PM Jacquelyn A. Jackson 1999 11 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Deeth Union Memorial Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Months 1 □ M 2 ☑ F 43 Yrs. 219-66-5745 Oct. 8, 1955 MAryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1336 North Freemont Avenue 21217 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 1 Yes 2 No If Yes, Give 1 Never Merried 2 ☐ Married 1 ☐ Yes 2√ No Specify: Specify: black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 4 teacher education 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Thurman Jackson Ethel 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lauren Muhammad/sister 3926 Tevis Circle, Randallstown, MD 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Fungrel Service Licensee 22. Name end Address of Fecility Many 8 Wade, Director State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock or heart feilure. List only one cause on each line. Intervat Between Onset and Death Immediete Cause (Finel diseese or condition resulting in deeth) 24 hours Metabolic Acidosis Due to (or as a consequence of): Pancreatitis 72 hours Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Acquired Immune Deficiency Synanome Due to (or es e consequence of):

physicien and s the buriel-transit The lew requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, for use es ed by the e or Attending Physician: After To the Hospital or Attending within 24 hours effer deeth.

To the Funeral Director: Afte completely filled in by the fun

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

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Department of Realth as Important: If Item 27 is any injury or other tres

**Physician** /Medical

Examiner

Examine

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Pages 1 and 2 should

Baltimore, Maryland 21215-0020

Directo

Funeral

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Completed

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Pert II. Other significant conditions of	ontributing to death but not res	sulting in the underlyi	ng cause given in	Pert I.	23b. Did tobacco use co	ntribute to the cause of death?  3 Probably 4 Unknown
					24a. Wes an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
25. Wes case referred to medical			26.	Place of Death	(Check only one)	
25. Wes case referred to medical exeminer?    Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA   Other: 4 Nursing Home 5 Resi	ne 5 Residence 6 Oth	ner (Specify)				
27. Manner of Death  1 Netural 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury M	28c. Injury et Work?	2 No	28d. Describe how injury occur	red

3 ☐ Suicide 4 | Homicide

29b. Signeture end title of certifier

6 Could not be determined 28e. Plece of tnjury - At home, ferm, street, tactory, office building, etc. (Specify)

28t. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated.

2 Medical Examinar: On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29c. License number

MIL asi MD

A72438946C12

29d, Date signed (Month, Dav. Year)

May 11, 1999

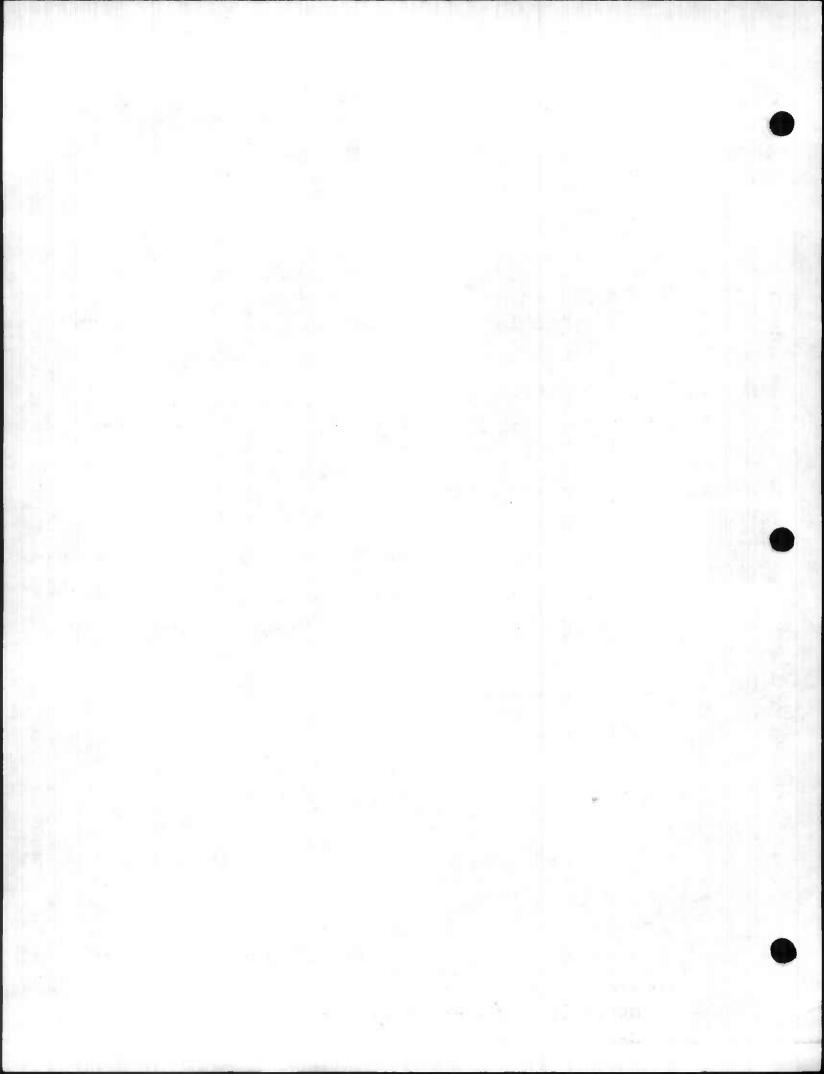
30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

University Parkway Baltimore, Maryland Union Memorial Hospital 201 East 31. Dete filed (Month, Day, Year)

State Registrar

1999 MAY 27

Begistrer's Signeture



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Mai 05AM /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7. Age In yrs. last birthday) albot Memor If Under 1 Year 5. Social Security Number 6. Sex Date of Birth (Month, Day, 9. Birthplaca (Stete or Foreign Country) **Funeral** Days 220-01-6098 Usual Residence of Decedent 100M 20F Yrs. Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 8 21613 Nerns 23s death by Funeral 12. Was Decedent Ever in U,S Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after of the fall and Mental Hygiene.
If item 27 is marked other than "natural", or item into or other traumate event, the Mental East man uny or other traumate event, the Mental East man 1 Never Married 2 Merried 1 Yes 2 No Baltimore, Maryland 21215-0020 1 Yes 2 No Specify Specity: (1) MIHe 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ARMCO nasing 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be To 19e. Intormant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other tra pncs. 5626 ShaRON Glen enneth WR 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Dete May 22 permit. Pages Department of h 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal trom State -BeLAIR 4 Donation 5 Other (Specify) 22. Name and Address of Fecility vans uneral 8800 10 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final da48 disease or condition resulting in death) Examiner Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Due to for as a been signed by the a should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2□ No 3 Probably 4 Unknown Records, Completed by 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes an autopsy performed? page 2 1 Yes 2 X No 1 ☐ Yes 2 XNo cartificata Vital or Attending Physician: director. Be 25. Was case reterred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Division of this funeral 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Aftar 5 Pending investigation 1 Natural within 24 hours after death. To the Funeral Director: A 2 Accident 1 Yes 2 No 6 Could not be determined 28t. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, lectory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) ţ, 29b. Signature end title of certifier 29d. Date signed (Month, Day, Year) 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) Easten, Maryland Idlewild Art. 50Ce 31. Date tiled (Month, Day, Teal)

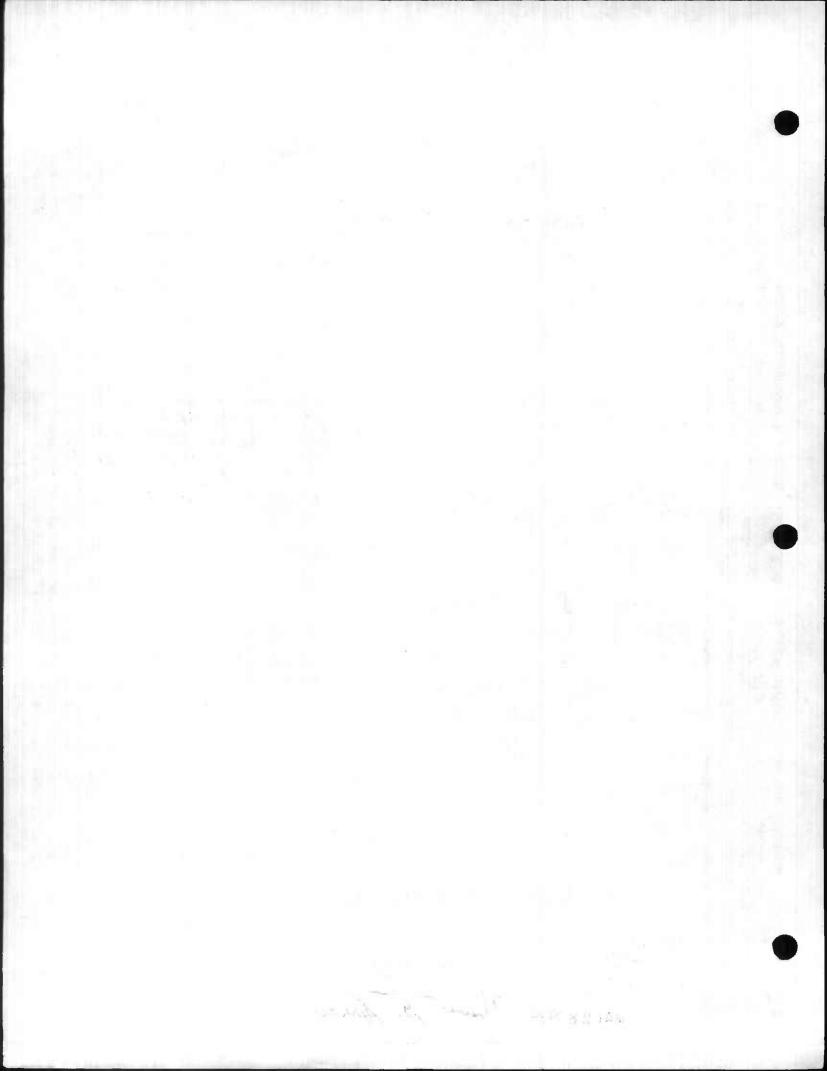
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State Registrar

DHMH 16 Rev 6/95

may 2 8 1999

32. Registrar's Signature S. Sports



1. Decedent's Name (First, Middle, Last)

Stella Maris Hospice

Stella

1□M 2QF

Apt. F

12. Was Decedant Evar in U,S. Armed Forces? 1 Yes 2 No If Yes, Give X Year or Dates:

College (1-4or 5+)

4a Facility Name (If not institution, give street end number)

10b. County

Baltimore

15. Decedent's Education (Specify only highest grada completed)

Krichton

7. Aga (In yrs. last birthdey)

Yrs.

Cockeysville

10c. City, Town or Location

Marie

216-05-0624

Maryland

11. Marital Status

10e. Street and Number

5. Social Security Number

Usual Residence of Decedent

5 Beehive Place

1 Never Married 2 Merried

3 ☐ Widowed 4 ☐ Divorced

Elementary/Secondary (0-12)

Physician

/Medical

**Examiner** 

**Funeral** 

**Director** 

"natural", or items 23s or 28s-f show officel Exeminer must be notified at

Director

Funeral

by

mpleted

with the Maryland

72 hours after

8 yrs.	Conlege (1-401 3+)	Home Maker		Own Hom	е					
17. Father's Name (First, Middle, Las	1)		18. Mother's Neme (Firs	st, Middle, Maiden Sumerne)						
Antonia	Bonanno	Gaetana Bianco								
19e. Intorment's Neme/Reletionship		et end Number or Rural Rou								
Mr. Norman Krichton	/ Husband	5 Beehive Place	Apt. F Cockey	vsville, Maryla	nd 21111					
20a. Method of Disposition		Pleca of Disposition (Neme of semetery, cremetory or other p	/eca) Da	te 20c. Location	City or Town, Stata					
1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	(y) Du	laney Valley Mem.	Gds. 5/27/9	9 Timonium	, Maryland					
21. Signeture of Funeral Service Lice	Off /	22. Name and Add	Irass of Facility	1050 York	Road					
Carl L.	/aness	Ruck Towson	Funeral Home, I	inc. Towson, Md	. 21204					
23a. Part1. Enter the disee a or con shock, or heart teilure. List of	plications that dused the deat one cause of each line.	h. Do not enter the mode of d	ylng, such es cardiac or res	piretory errest,	Approximete Interval Between					
Immediate Course (Singl	/				Onset and Death					
Immediate Cause (Final disease or condition resulting in death)	CONGESTIVE	HEART FAILURE	3							
	Due to (d	or as e consequenca of):								
Commented to the second	b	r ac a consequence at\.								
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying	Due to (c	r as a consequenca of):								
Cause (Disease or injury that initieted events	C. Due to (o	r as a consequence of):								
resulting in death) Last										
d										
Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.  23b. Did tobacco use contribute to the cause of death										
1 ☐ Yea 2 ☐ No 3 ☐ Probebly 4X ☐ Unkno										
Completed by	24a. Was an autopsy 24b. Were autopsy tindin									
24a. Was an autopsy performed?  24b. Were autopsy to available prior to completion of confident?										
								25. Was case reterred to medical		no Disease (Desait 10)
25. Was case reterred to medical axaminer? 1 \sum Yes 2 \overline{X} No	Hospitai:	26. Placa of Deeth (Check only one)  ital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 8 XOther								
27. Manner ot Death	28a. Dete of Injury (Month, Dey Year)	28b. Time of 28c. In		me 5 ☐ Residence 8 <b>X</b> Other (Specify) HOSE 28d. Describe how injury occurred						
1 X Neturei 5 ☐ Pending 2 ☐ Accident investigation	n		□ Yes 2 □ No							
3 ☐ Suicida 6 ☐ Could not l 4 ☐ Homicide determined		ome, tarm, street, tectory, offic		ocation (Street and Numl City or Town, Stete)	Number or Rural Route Number,					
			City or I own, Stele)							
29a. Certifier (Check only 2   Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.										
one) and manner stated.										
29b. Signeture and title of certitier	1_	43725		25199						
-			13/25	3 12	-3117					
30. Name and address of person who										
DR. TARIO MAH 31. Date filed (Month, Day, Year)	MOOD 2300 DUL	ANEY VALLEY RI	. TIMONIUM,	MD 21093						
WAY 2 8 1999	Serence !	1. Aroust 1								
2411 10 10 10 10	1	Popolici								
5										
		ORIGINAL								

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔾 🔾 Certificate of Death

If Undar 1 Yaar

10f. Zip Code

21030

1 ☐ Yes 2 XNo Specify:

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)

Days

Months

2. Date of Death Month Dey May 23, 1999

8. Dete of Birth (Month, Dey, Year) April 13, 1912

4b. City, Town, or Location of Death

Timonium

If Under 24 Hrs.

Hours

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.)

3. Time of Death

8:00 p.m.

Birthplaca (Steta or Foreign Country)

10d. Inside City Limits

1 Yas 2 No

Maryland

Year

4c. County of Death

10g. Citizen of What Country?

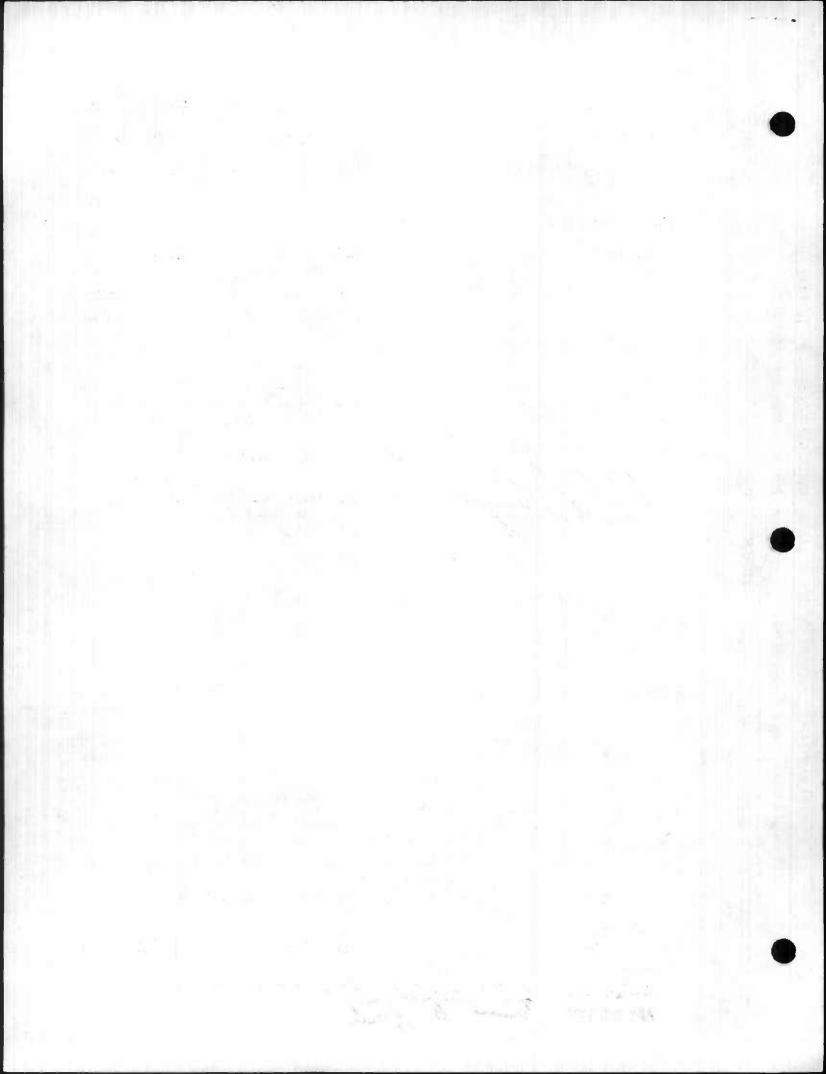
14. Rece - American Indien, Black, White, etc.

specify: White

16b. Kind of Business/Industry

U.S.A.

Baltimore



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 u **Physician** Joseph Lannon 20 1999 10:13 /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not Institution, give street and number) 4c. County of Death Examiner Baltimore Union Memorial Hospital If Under 1 Year 8. Dete of Birth (Month, Dey, Year) Oct. 2, 1935 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) If Under 24 Hrs. **Funeral** Deys Months Hours 10XM 2□ F 63 Yrs Director 577-46-2478 Maryland Usual Rasidance of Decedent 10a. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Yes 2 No Directo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Nerns 23s 115 E. Melrose 21212 U.S.A. death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 11. Merifel Stetus filed within 72 hours after 1 Never Merried 2 Married 1 XYes 2 No If Yes, Give Yeer or Detes: unknown natural', or aitimore. Maryland 21215-0020 1 ☐ Yas 🏖 ☐ No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 Map maker Government permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other treumatic event page. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) 8 2 Thomas Lannon Agnes Davis 19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Elizabeth Spaulding/sister 40 E. 26th Street, Baltimore, MD 21218 20b. Piece of Disposition (Neme of 20a. Method of Disposition 20c. Location - City or Town, Stete cemetery, cremetory or other piece) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stete 4 Nonetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licansee 22. Name end Address of Fecility Director Ronald S Wade State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 25s. Part1. Enfer the disease, or shipck, or heart failure. List Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel diseese or condition resulting in death) Examiner Due to (or as e consequence of): pneumoni2 attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es e consequenca of): Records, P.O. Box 68760 Physician/Medical Due to (or as a consequenca of) Part II. Other significant conditions confributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown cordioanyopathy þ Be Completed 24b. Were autopsy findings available prior to 24a. Wes en autopsy performed? completion of cause of death? Ther insufficience 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific 25. Was case referred to medical examinar?
1 ☐ Yes 2 ☑ No 26. Placa of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) Medical Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Metural 5 Panding 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida To the Hospital of within 24 hours a To the Funeral Completely filled in the Completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and piece, and due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and menner stated. 29e. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and fitle of certifier AT 2438946 301 Esst University Parkery Baltimore 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Union Memorial

**DHMH 16 Rev 6/95** 

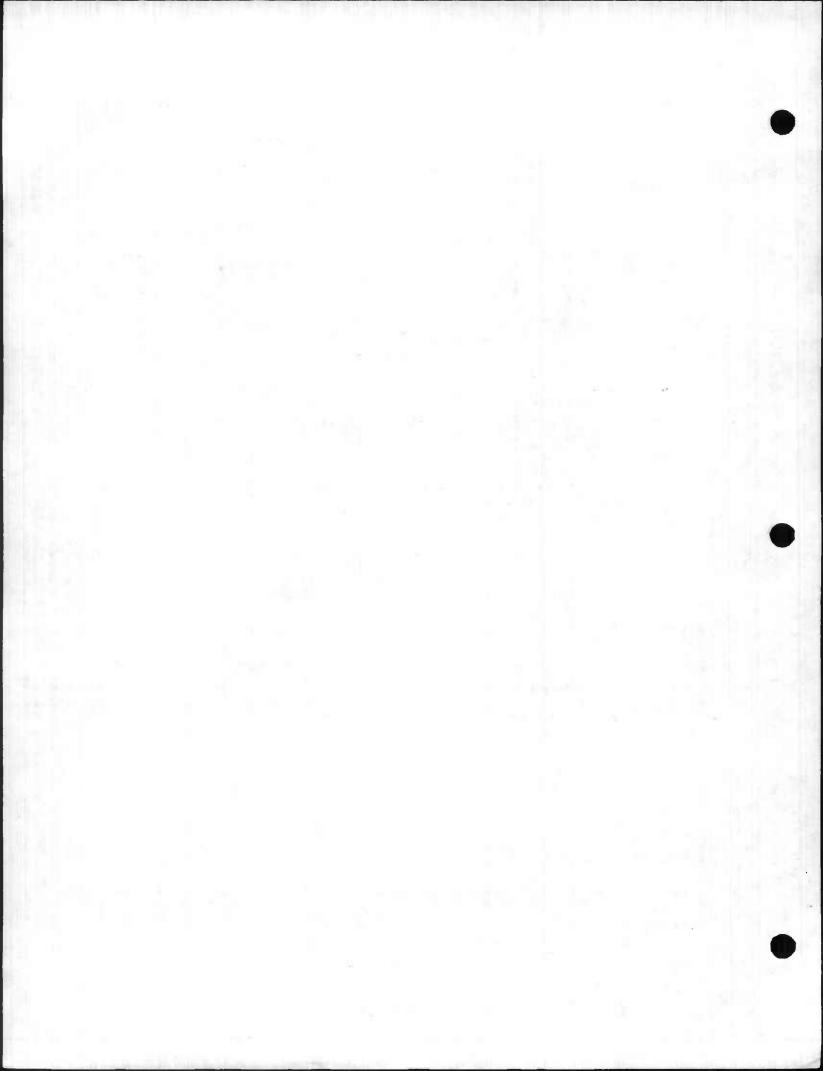
State

Registrar

31. Date filed (Month, Day, Year) MAY 28

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32. Registrer's Signeture



#### Piease Type or Print in Biack Indelibie Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year EVA LEGUM 1999 MAY 24 9:30PM 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth COLUMBIA LORIEN NURSING HOME HOWARD If Under 1 Year | If Under 24 Hrs. Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Months Hours 1□M 2X F Yrs. 213-26-7378 JUNE 1, 88 1910 MARYLAND Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No HOWARD COLUMBIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5619 THICKET LANE USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S Armed Forces? 11 Marital Status 14. Race - American Indian, Bleck, White, etc. 1 Never Merried 2 Merried 1 Yes 2 No WHITE 1 Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced Year or Detes: 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) MILLINER CLOTHING 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) ABRAHAM BARR DORA WHITMAN 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 5619 THICKET LANE MRS. MARJORIE BERMAN (DAUG.) COLUMBIA, MD 21044 20e. Method of Disposition 20b. Place of Disposition (Name of Dete 20c. Location - City or Town, Stata cematary, cremetory or other place) 1 Suriel 2 Cramation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 5/26/99 MIKRO KODESH BETH ISRAEL BALTIMORE, MD 21. Signatura of Fundamental Service Licent 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. 21208 PIKESVILLE, 23a. Pert1. Enter the or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, but only one cause on each line. Approximete Intervel Between Onset and Death Immediete Cause (Final disaese or condition resulting In death) Due to (or as a consequence of): Sequentially list conditions, if any, laeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Pertorius Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 20 No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Wes an autopsy performed? 2 10 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical axeminer? 26. Placa of Deeth (Check only one) 1 Yas 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Menner of Death Dete of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Neturel 5 Pending invastigation Injury 1 Yes 2 No 2 Accident

The law requires that the death certificate be executed physician and the burial-transit P.O. Box 68760, 60 60 signed by t Records, page 2 should certificate of Vital director. this

Physician

/Medical

**Examiner** 

**Funeral** 

Director

Herna 23a or 28a-f show

death

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

and Mental Hygiene.

permit. Pages 1 and 2 Department of Health s Important: If Itam 27 is eny injury or other tra

**Physician** 

/Medical Examiner

3altimore, Maryland 21215-0020

Director

Funeral

à

Completed

Be

2

MD

traumatic avant, the Medical Examinar must be notified at

natural, or

Examiner Physician/Medical þ Completed Hospital or Attanding Physician: Be edicai Certification: To After Division death. within 24 hours after deat To the Funeral Director: illed in by the

> State Registrar

31. Dete filed (Month, Day, Year) MAY 2 8 1999

3 Suicide

29a. Cartifier

29b. Signetur

4 ☐ Homicide

and tilla of certifier address of person

6 Could not be determined

2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner steted.

28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

mo

29c. License number

💢 CertifyIng Physician: To the best of my knowledge, deeth occurred et the time, dete end placa, end due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

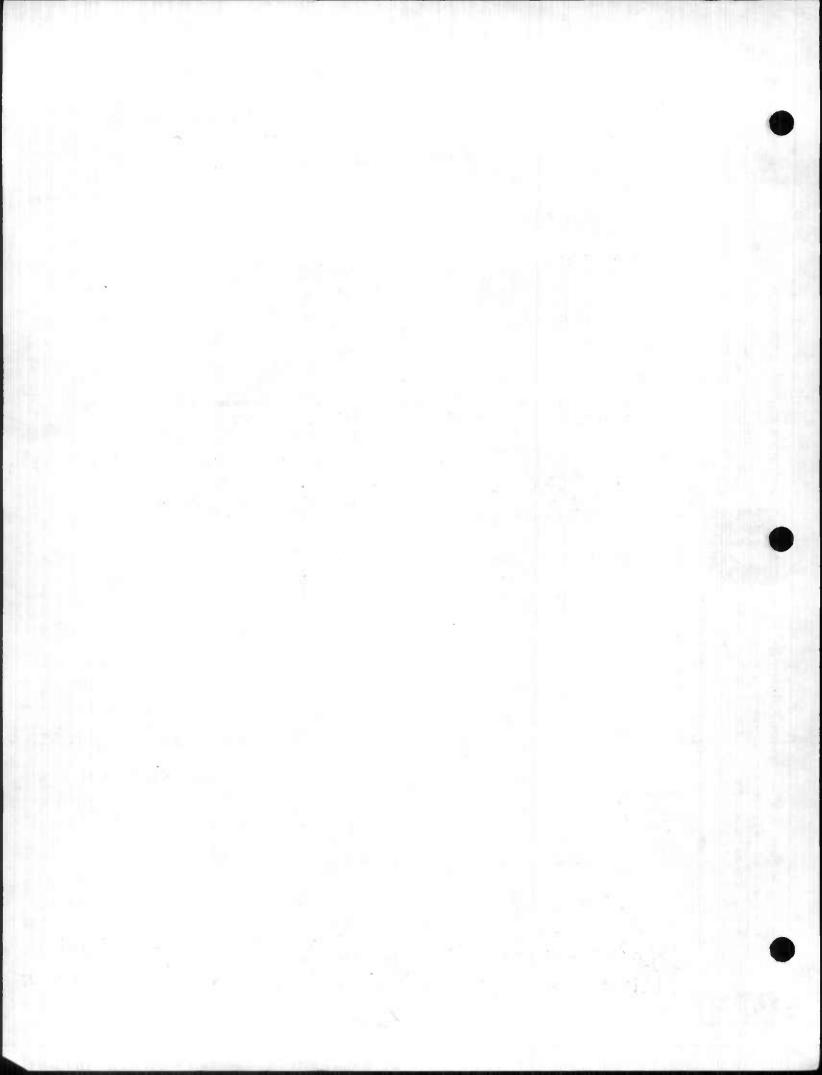
29d. Deta signed (Month, Day, Year)

who pempleted cause of death (Item 23a) (Type, Print) 2410

32. Registrer's Signeture

**DHMH 16 Rev 6/95** 

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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED ITEM#23a PER M.D. G771 5/28/99 AH 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Moore 15:42 May bhn /Medical 4a. Facility Name (If not institution, giva street end number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Maryland Baltmore Baltmore Medica Center University if Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Birthplace (State of Foreign Country) Days XXM 2 F Months 214 76 7753 40 Feb. **Director** 11,1959 California Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. tnside City Ltmits Maryland n/a **Baltimore** 1X Yes 2□No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3612 Mary Ave. 21206 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 11. Marital Status 14. Race - Amarican Indian Armed Forces? Btack, White, etc. 1 Naver Married 2 Married 1 Yas 2 No Specify: White by 3 Widowed 4 Divorced Year or Dates: Be Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Bustness/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Construction 11 Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Roy Allen Moore Patricia Ruth Guest 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 end 2 a Department of Health er Important: if Itam 27 is any injury or other trau Patricia R. Bitzel / Mother 1813 Wentworth Rd., Baltimore, MD 20b. Place of Disposition (Neme of cemetery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Buriat 2 【Cremation 3 ☐ Ramovel from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 5/11/99 Baltimore, MD 22. Nama and Address of Facility 21. Signature of Funerat CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD lyseux Offerian 23a. Part1. Enter the disaase, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Physician 6/2 hours /Medical Immediate Cause (Final disease or condition resulting in death) ravdiopulmonary Examiner Due to (of as e consequence of): Examiner CARDIAC ARRHYTHMIA Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Physician/Medical Due to (or as a consequence of): Part ti. Other significant conditions contributing to death but not resulting in the underlying cause given tn Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Nephrectory and þ thrombectomy due to 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy Vascular thrombus 1 Yes 2 □ No 1 Tyes 2 No 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) Hospital: 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nurstng Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Dete of tnjury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending

physicien end s the buriel-transit thet the death certificate be executed Box 68760. P.O. Records, certificate Division of Vital Hospital or Attanding Physician: this funeral After s after deeth.
If Director: Aft
ad in by the fu filled in by

with the Maryland

death

Pages 1 and 2 should be filed within 72 hours efter nent of Health and Mentel Hygiene.

3altimore, Maryland 21215-0020

or 28a-f show

items 23a

0

"natural",

Hygiene.

69

Medical Examiner must be notified at

Certification: To 1 Netural 2 Accident 1 Tes 2 No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certitier (Check only one)  12 Certifying Physician: To the best of my knowledg (Check only one)  13 Certifying Physician: To the basis of examinetion a and manner stated.	ie, daath occurred at the time, dete and place, and nd/or investigation, in my opinion, death occurred	d due to the ceuse(s) and manner as stated. at the time, dete end place, and due to the cause(s)
29b. Signatura and title of certifiar	29c. Licanse number	29d. Date signed (Month, Day, Year)

30. Name and eddress of person who comptered co use of death (item 23e) (Type, Print)

O(Type, Print)
Undergy, University of Manyland Medical Center of MICHAEL SZOSTAK 31. Date filed (Month, Dey, Yeer) NifAY 2 8 1999 32. Registrar's Stgnature

State Registrar

Medical

• Funerel within 24 hour To the Funer completely file

To the

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day MARTIN Month MONROE HARVEY 1999 1.00 am MAY 25 4e Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death SAMARITAN BALTIMORE HOSPITAL GOOD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 25 1912 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Months Davs Hours 1QM 2□ F June 213-05-3401 86 Usual Residence of Decedent 10b. Counts 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD. Baltimore Baltimore 10a. Street and Number 10f Zin Code 10g, Citizen of What Country? 21212 USA 821 Kingston Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Bleck, White, etc. 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 1 Never Married 2 XMarried 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Operating Engineer 18. Mother's Nama (First, Middle, Maiden Surname) 17. Father's Nama (First, Middle, Last) Sarah Jane Skipper Harvey Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 821 Kingston Rd. Baltimore, MD. 21212 Mrs. Betty Martin/Wife 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriat 2 Cremation 3 Removal from State 4 Donation 5 Othar (Specify) 5-28-99 Parkville, MD. Moreland Mem. Park 21. Signature of Funeral Service License 22. Name and Address of Fecility Ruck 1050 Towson Funeral Ho York Rd. Towson, Funeral Home, lnc. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Ceuse (Final MYOCARDIAL INFARCTION disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if eny, laading to immediate cause. Entar Underlying Cause (Disease or injury that initiated evants resulting in death) Last Due to (or as e consequence of): Due to (or as a consequence of): Part ff. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Dfd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown LOWER LOBE PNEUMONIA 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? ACUTE LEUKEMIA completion of cause of death? 1□ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was casa referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1□ Yes 3☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 12 Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? 5 Pending Invastigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Examiner P.O.

physician and the burial-transit attending signed by d peen Division of Vital Attending Physician: funeral After of or Attending after death. Director: Att Hospital 24 hours a 24 hours a To the Hosp within 24 ho To the Fune completely fi

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/Medical

Examiner

Director

Funeral

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Certification:

Medical

**Funeral** 

Director

r than "natural", or items 23s or 28s-f the Medical Examiner must be notifie

al Hygiene.

permit. Pages 1 and 2 should be fill Department of Health and Mental H Important: if Item 27 is marked oth any injury or other traumatic even

**Physician** /Medical

Maryland 21215-0020

altimore,

Certifying Physician: To tha best of my knowledge, death occurred at the time, data and place, and due to tha cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, data and place, end due to the cause(s) end manner stated. 29a. Certifier (Check only one)

29b. Signature and title of certifier

MD, RESIDENT

29c. License number

29d. Data signed (Month, Day, Year)

30. Name and address of person who complated causa of death (Item 23a) (Type, Print) ANU GABA RESIDENT, GOOD SAMARITAN

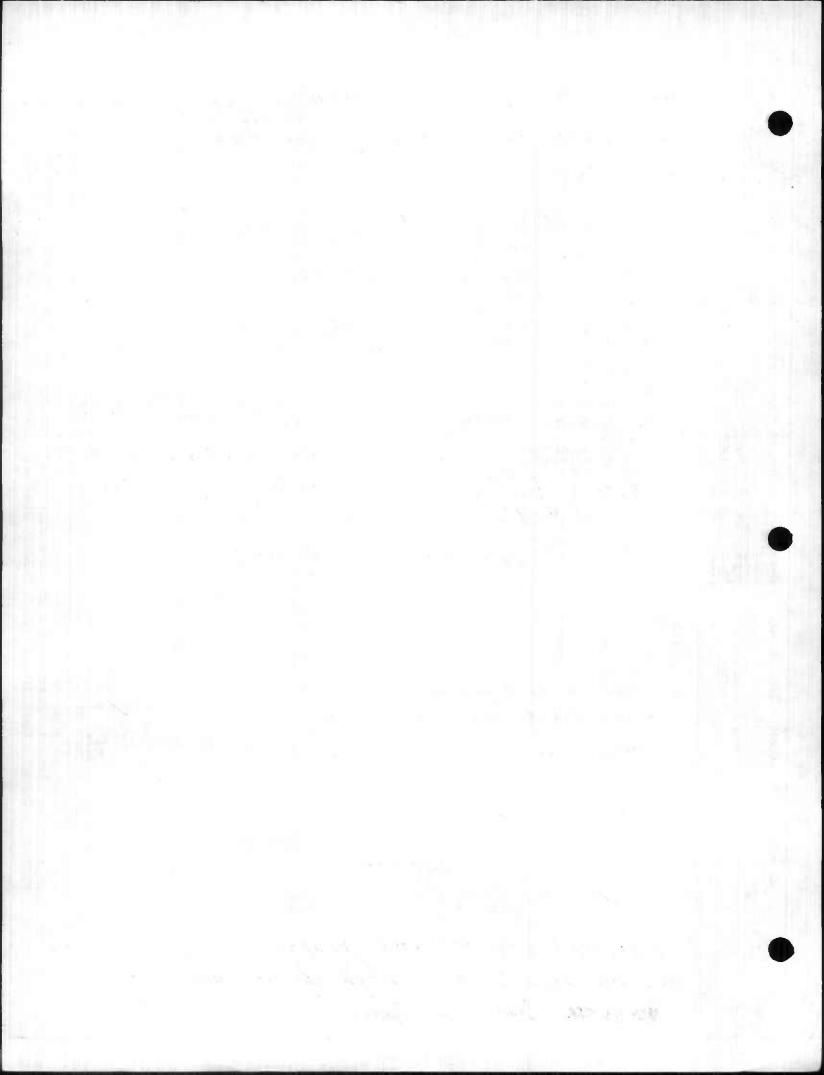
HOSPITAL, BALTIMORE

Registrar

31. Date filed (Month, Day, Year) MAY 28 1999







Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Shirley Katherine Mellon 4b. City, Town, or Location of Death /Medical 27 1999 4c. County of Death 4:00 AM 4a Facility Name (If not Institution, give street and number) Examiner Saint Joseph Medical Center Towson Baltimore If Under 24 Hrs. If Under 1 Yaar Birthplece (State or Foreign Country) 7. Aga (In yrs. last birthday) Funeral Deys Months Hours 1 M 20 F 60 Yrs Director W.Virginia 215-34-9010 Usual Rasidence of Decedent 10a State 10c. City, Town or Location 10b. County 10d Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at the Maryta 1 X Yes 2 □ No Director Baltimore Md 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3811 Elmley Avenue 21213 USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 (D) Yo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apacify Cuben, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indien, 11 Marital Status Black, White, etc. 1 Never Merried 2 Married 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White 2 semit. Pages 1 and 2 should be filed within 72 hours i Department of Health and Mental Hygiene. Important: If tern 27 is manked other then "naturel". o 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) 12 Administrative Manager Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) 88 George W. Smith Ann White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald F.Mellon -Husband 3811 Elmley Avenue, Baltimore, Md. 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 8 4 Donation 5 Other (Specify) Hilltop Service Corp. 5-28-99 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Leonard J. Ruck Funeral Home Inc. 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Md. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final PNEUMONIA disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner physician and s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be execu Box 68760. Physician/Medical Due to (or as a consequence of): attending p 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by t 2 No 1 Yee 3 Probably 4 Unknown CACHEXIA þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peeu certificate 2 NO NO director. Be 25. Was case referred to medical 26. Place of Death (Check only one) axaminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 1º 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Time of After 5 Pending invastigation Naturat if or Attanding after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicida 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 24 hours a Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier edicai (Check only one) To the I within 2 To the I 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 90 D 37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOON P. LIM M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

AH(2)

Registrar

MAY 2 8 1999

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** Theodore Moore May 26, Charles 1999 9:00 AM /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 810 Seaword Rd. Towson Baltimore 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. 9. Birthplaca (State or Foreign Country)
MD. 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 12 M 2□ F Yrs. 213-20-9608 75 09/03/1923 Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location r than "natural", or frame 23a or 28a-f ahow the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 810 Seaword Rd. 21286 USA Funeral permit. Pages 1 and 2 about be filed within 72 hours effer dea.
Important if itsen 27 is marked other than
any Injury or other traument 12. Wes Decedenf Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Merital Status Bleck, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 🛣 No If Yes, Give 1 ☐ Yes 2 ☒ No Specify: à 3 XWidowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 12 College (1-4or 5+) Sales Engineer Air Conditioning/Heat 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) 8 James Gellispe Blane Moore, Sr. Mamie Overbeck 19a. Informant's Neme/Retetionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Michael E. Moore (son) 810 Seaword Rd. Towson, MD. 20b. Ptece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 

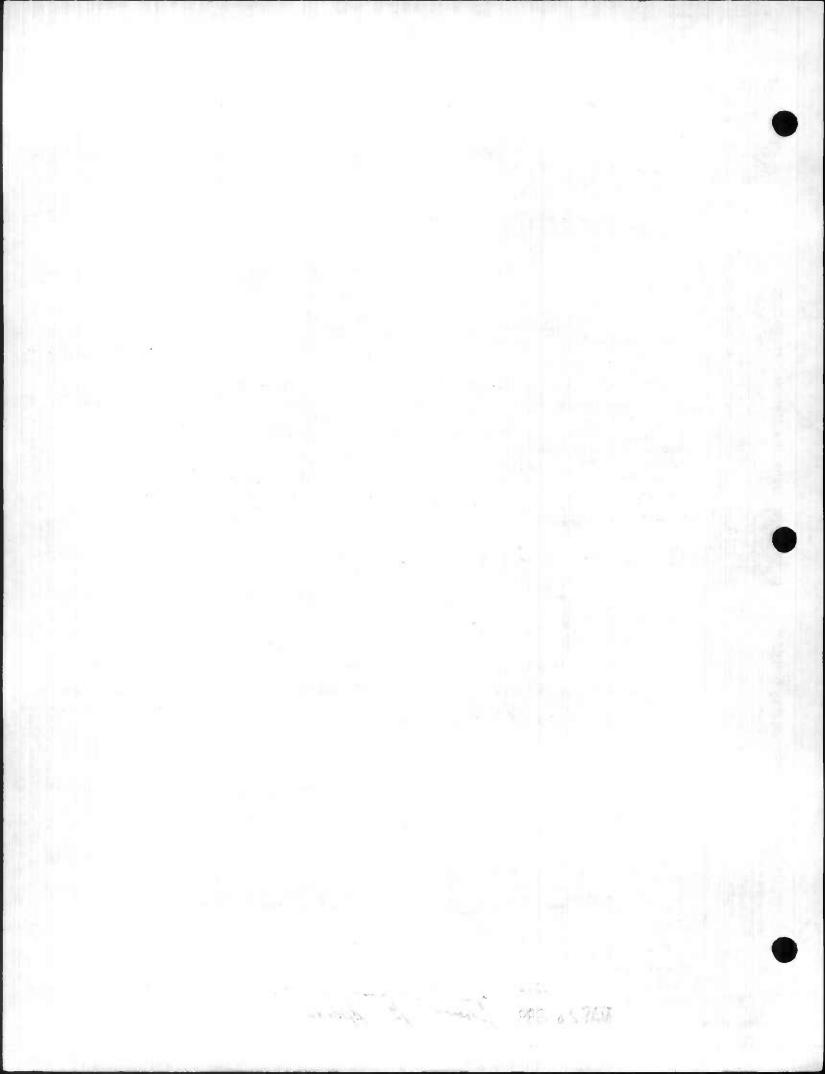
■ Buriel 2 

□ Cremetion 3 

□ Removel from Stete Dulaney Valley Mem. Grdns. 6/1/99 Timonium, MD. 4 ☐ Donetion 5 ☐ Other (Specify) Carroll 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funerel Service Lionard Jenn 15)C. 1050 York Rd. Towson, MD. 23a. Part I Inter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart failure. List only one cause on each line. Approximate tnterval Between Onset end Death **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical Examiner Examiner physicien and the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es a consequence of) P.O. Box 68760 Physician/Medical Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown Division of Vital Records. þ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attanding Physician: 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4□ Nursing Home 5% Residence 6 □Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Menner of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? After Netural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Coutd not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 022342 30. Nema and address of person who completed cause of death (Item 23a) (Type, Print) 200 E 33.d. S+ #501, Belto, md 21218 Michael. N. Rubinstein M.O. 32. Registra Signature 31. Date filed (Month, Dey, Year)

State Registrar

MAY 28



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

TEM: #1 PER	MD G771 5-28-99 WR.	Otato or ma	ryland / Depa <i>Ce</i>	rtificate			IIG IVI		a. No.		712	1
Physician	1. Decedent's Name (First, Middle, Las	DIANE DIA	NE PITTMAN					2. Date of Death Month		Year 1999	3. Time of	Death 34Pm
/Medical Examiner	4e Facility Name (If not institution, give C+v R U+ 1005					b. City, Town		ation of Death	4c. County			711
Director	210-30-3307	7. Age	(In yrs. last birthday) 47 Yrs.	If Under Months	1 Year Deys	If Under 24 Hours	4 Hrs. Min.	8. Dete of Birth (Month, Day, June 21,	1951	9. Birthpl	aroli	or Foreign Lna
2	Usual Residence of Decedent  10a. Stele 10b. County 10c. City, Town or Location  MD N/A Baltimore									10	od. Inside C	Ity Limits
th with the Maryla 23a or 28a-f sho ust be notified at ral Director	10e. Street and Number 1704 East Lanvale		10f. Zip		21213	3 USA						
ar, or hams Examiner in by Funer	11. Marital Status  TO Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Et Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Wes Deced			n? (Spec Puerto F	cify Yes or No- lican, etc.)	Blec	e - America k, White, e	etc.	
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narked off natic ever	17. Fether's Name (First, Middle, Last)  Jessie Pittman  10. Informati's Name (Polisianskin (Fig. 1))	ima Print	40h Marit	an Address	(Street e	Ru	ıby I	(First, Middle, Mi			Codel	
of Health ar I from 27 is r other trace	19e. Informant's Name/Relationship (T Ruby Pittman (Mot		201	N. W	ashi			Apt. 70	1 Balt	o, Mc	1 2123	31
ury or	20a. Method of Disposition  1 M Burial 2 Cremation 3 1  4 Donation 5 Other (Specify,  21. Signal by of Funeral Service Licens	)	20b. Place of Disponentery, cre.  Mt. Zion	Ceme:	ther place tery		5/2		ansdow	me, l		and
Depart Importu any inji once	1 Dans	cal	5	502 W	inne	r Aver	rue	Baltimor	e, Mar	yland	1 2121	15
hysician /Medical Examiner	Immediate Cause (Final disease or condition resulting In deeth)	a. PNEU					ardiac of	respiratory arres	st,	1	Approximal Intervat Bet Onset and	tween Death
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\$ E	Cause (Disease or Injury that initiated events resulting In death) Last	c. A 105	ue to (or as a c <i>on</i> sec	juence of):							Terric	3
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been s should	hwemia							24a. Was en perform		ava	re autopsy nilable prior npletion of death?	to
	TITAMBO WTO	PEMA					15 4	1 ☐ Yes			Yes 2	,
2	examiner?	Hospital: 1 Inpatient				er: 4 Nurs	ing Hom	(Check only one ne 5 ☐ Resider 8d. Describe how	ice 8 🗆 Oth		)	
To the Functal Director: After th completely filled in by the funeral Medical Certification:	1 Shatural 5 Pending Investigation 3 Suicide 4 Homicide 6 Could not be determined	28a. Date of Injury (Month, Day) 28e. Plece of Injury building, etc.	y - At home, farm, str	М		(? Yes 2 □ N	0	8f. Location (Stre City or Town,	eet and Numb		l Route Nun	nber,
in 24 hour he Funera pletely fille edical (	29a. Certifler 1 Certifying Phy cone) 2 Medicat Exami	sician: To the best of iner: On the basis of e and manner state	xamineti <i>on</i> and/or in	n occurred a vestigetion,	at the tim in my op	e, date end pinion, death	plece, e occurre	nd due to the car d at the time, da	use(s) and me te and place,	nner as stand due to	ated. the cause(s	s)
Tothy	29b. Signature and title of certifier	Brw	~		License	number 974	,		d. Date signed			
3	30. Name and address of person who co		th (Item 23a) (Type, 9% N S/L		~ 1	3 Mity	- 0.5		2123	1		

Registra DHMH 16 Rev 6/95

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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month POOLE 8:00 RM WILLIAM MAY 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SECOUR HOSPITAL BALTIMORE BON If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Days Months Hours 1 M 2 F 214-58-7281 JULY 31,1951 SOUTH CAROLINA Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No BALTIMORE NIA MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? N. PULASKI STREET 21223 0.S.A. 103 14. Race - American Indian, 12. Was Decedant Evar in U.S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Naver Married 2 Married 1 ☐ Yes 21 No Specify: Specify: BLACK 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elemantary/Secondary (0-12) Coltega (1-4or 5+) POWER CON CORPORATION TOOL CRIB OPERATOR UNKNOWN 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Melden Sumame) POOLE SOHNNY DANIELS MONTEZ 19a. Informant's Name/Relationship (Type, Pnint) 19b. Meiting Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) LEOTHA POOLE (WIFE) 103 N. PULASKI STREET, BALTIMORE, MARYLAND 21223 20b. Place of Disposition (Nema of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 05-28-99 WOODLAWN, MARYLAND KING MEMORIAL PARK 5. Other (Specify) 4 Donation 21. Signature of 22. Nama and Address of Facility Funeral Bervice Lice JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVENUE, BALTIMORE, MARYLAND Q1217 23a. Part1. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one ceuse on each line. Approximata Interval Between Onset and Deeth Immediate Ceuse (Final monthy une Calcinona diseese or condition resulting in deeth) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of causa of deeth? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 200 No 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No 2 ER/Outpatient 3 DOA 27. Manner of Deeth Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Tima of 28d. Describe how Injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicida 28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

attending physician for use as tha bune signed by the a should I certificeta has t irector, page 2 s Physician: director this

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

"natural", or items 23a or 28a-f show

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and Mental Hygiene. Is marked other than

Department of Haalth and Mental

If item 27 is

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**Physician** /Medical

Examiner

Physician/Medical Examiner

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Certification:

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29a, Certifier

29b. Signatura and title of sedifier

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72 hours efter

certificate be executed Box 68760 o Division of Vital Records. al or Attending Physis efter death.

M Director: After this ed in by the funeral di To the Hospital or within 24 hours eff To the Funeral Di completaly filled in

> State Registrar

31. Date filed (Month, Dey, Yeer) MAY 2 8 1999

on who completed cause of deeth (Item 23a) (Type, Print) racikly us

32. Regiatrar's Signature

821 N. Eutow Steet, suite 407, Baltimore, MD 21201

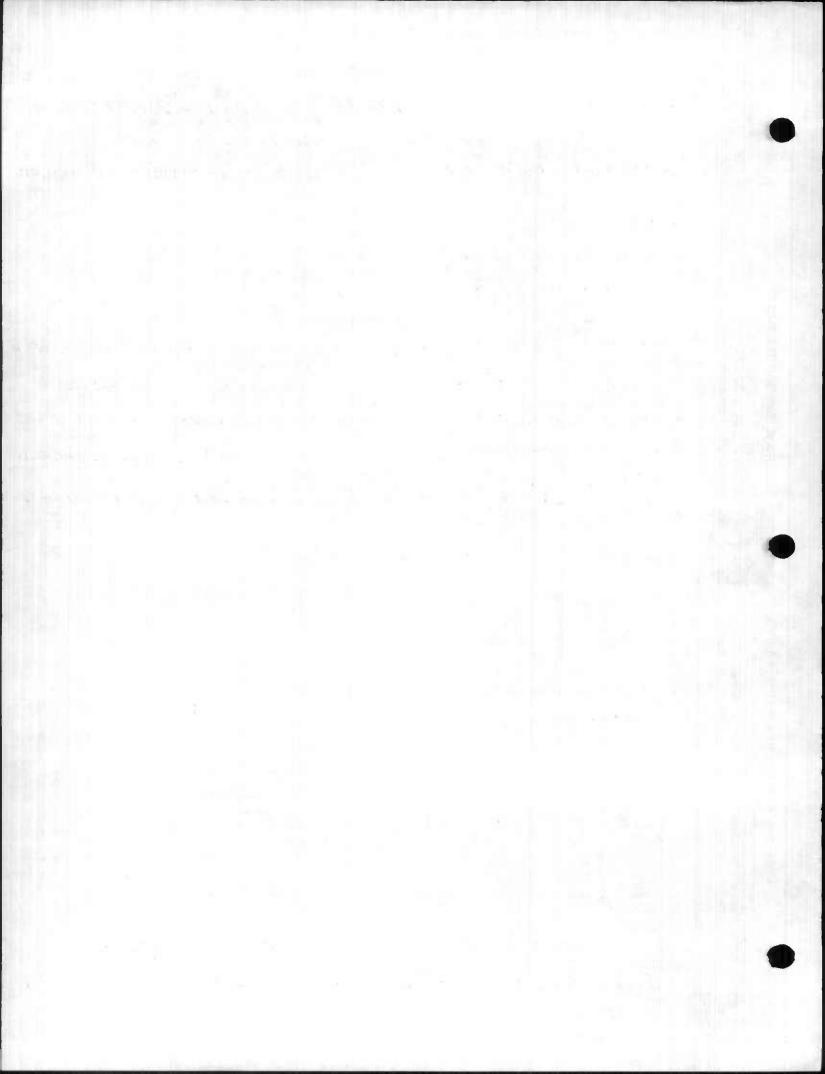
Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and menner es stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29c. Licansa number

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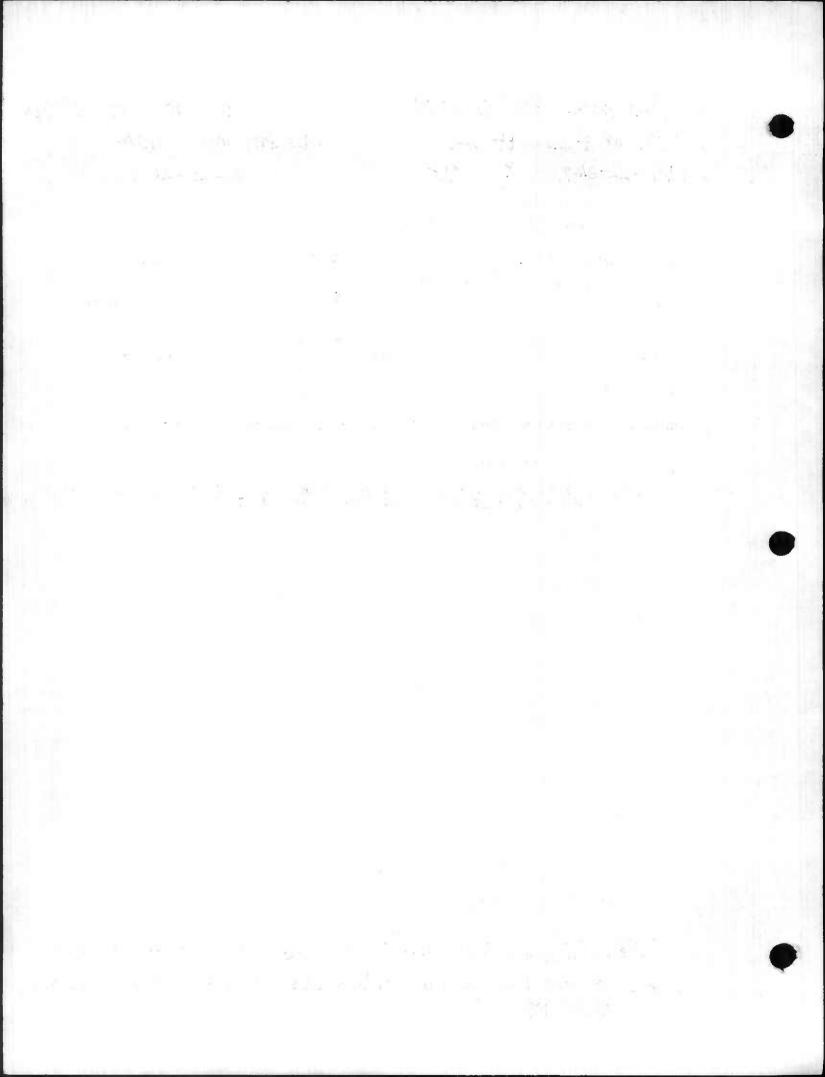
29d. Date signed (Month, Day, Year)



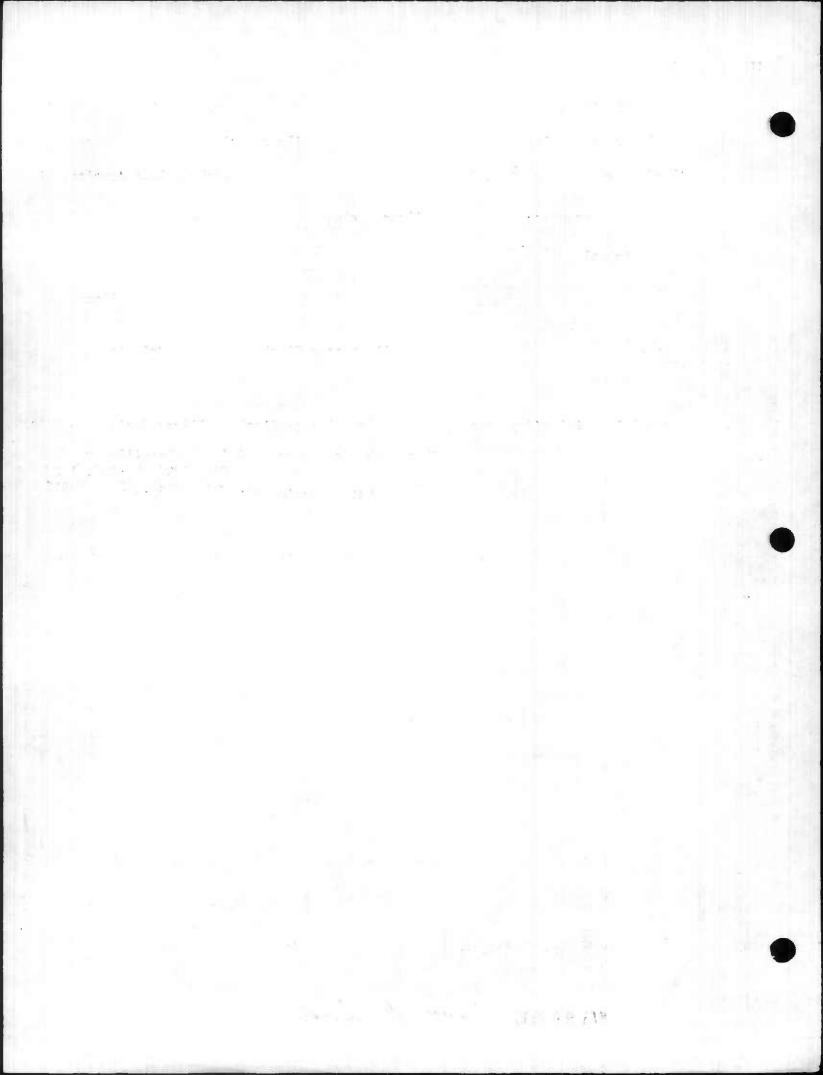
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State of Maryland / Department of Health and Mental Hygiene

		1. Decedent's Neme (First, Middle, La	^			tificate of		2. Date of D	Reg. No.		3. Time of Death		
Physici /Media		n ICNINIS PETERCON						Month 5	I Dey	Year 99	8:30/		
Examir		4e. Facility Name (If not Institution, giv		)				or Location of Dea		y of Death	27		
			nott i	25		Williamond	ADELP			SA			
Funeral Director		5. Social Security Number 6. S 577 -22-3/67  Usual Residence of Decadent	ex	ge (In yrs. 1	last birthdey) Yrs.	Months Deys		lin. (Month, C	irth Dey, Year) 5 - 2 D	9. Birthp Cour unkno	place (State or Fore htry) WII		
yland		10e. State 10b. County		10c. City	y, Town or Loc	cation				1	0d. Inside City Limi		
Mar market	ctor	Maryland Hyattsv:	ille	Land	dover						1 ☐ Yes 2 💢 N		
or 28	Director	10e. Street end Number				10f. Zip Code			10g. Citizen of	What Cour	ntry?		
ath w	rai	1705 Countrywood				207							
J within 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 28e-f show the Medical Examiner must be motified at	by Funeral	11. Meritel Stetus  1 Never Married 2 Merried  3 Widowed 4 Divorced	12. Wes Decedent Armed Forces? 1  Yes 2 If Yea, Give Year or Detes:	Ever in U, Punkno No		Vas Decedent of Yes, specify Cul		(Specify Yes or Nuerto Rican, etc.)		ack, White,	etc.		
72 hor	pete	15. Decedent'a Ed	fucetion		18a. Deced	ent's Usuel Occu	pation	una dela a	16b. Kind of i	Buainess/Inc	dustry		
TI CO. L	Completed	(Specify only highest gra  Elementery/Secondery (0-12)  unknown	grade completed)  College (1-4or 5+)  unknown  (Give kind of work of life. DO NOT use				during most of a	unkn	own				
be filed htal Hygie d other event,	BeC	17. Father's Name (First, Middle, Last)					18. Mother's I	Name (First, Middl	e, Maiden Suma	U.S.A.  14. Rece - American Indian, Black, White, etc.  Specify: white  Kind of Buainess/Industry  unknown on Sumame)  For Town, State, Zip Code)  D 20783  Location - City or Town, State  Baltimore Street  Approximate Interval Between Onset and Deeth  2			
should but marked	To	unknown					unknow	n					
0 8 8 8		19a. Informent's Name/Relationship (									Code)		
1 and Health em 27 rther tr		Heartland Health 20e. Method of Disposition	Care Cent				t Rd.,	Adelphia			State must		
permit. Pages 1 and 2 should be file. Department of Health and Mental Hy important: If item 27 is marked other important: or other traumatic event, once.	0 4	1 □ Buriel 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 ☑ Other (Specify) in State											
permit. Departr imports sny inje		22. Name end Address of Facility State Anatomy Board, 655 W. Baltimore Stree Baltimore, MD 21201											
		23a. Part. Enter the disease, or com shock, or heart fellure. List only	plications that cause one ceuse on each l	d the death ine.	. Do not ente	er the mode of dy	ing, such ea cerd	dac or respiratory	arrest,		Interval Between		
Physician /Medical Examiner		Immediete Cause (Final disease or condition	a CUNGE	בירו אב	VE HE	EART F	AILUR	Ē.					
	<u>ا</u>	resulting in death)	4	Due to (or	r as a consequ	uence of):							
uted d ansit	Examiner		b. Ante	no.	CLEN	mc CA	2DIOVA	swiar 3	SETTE		y eg n		
an an										-			
ificata be executed g physician and as the burial-transit	edicai									1			
E 0 4	92		d							1			
eath cer attendin for use	clan												
that the death led by the atter detached for u	Physician/								23b. Did tobacco use contribute to the cause of				
es that igned t be det	by P	Diabets h	ellitus	ty	e 11			_   ''	J 100 2LINO	3 Proi	bebly 4 Honkno		
requir been s should	Completed							24a. Wa per	s an eutopsy iormed?	ava	ere autopsy findings alleble prior to mpletion of cause death?		
The law te has sage 2	mo.							10	Yes 2 No		Yes 2□ No		
	BeC	25. Was cese referred to medical examiner?					26. Place of I	Death (Check only	one)				
	ပ္	1 Yea 2 No	Hospital: 1 Inpatie	ent 2 1	ER/Outpatient	3LI DOA		g Home 5□ Res	sidence 6 🗆 Ot	her (Specif)	y)		
5 2 5	Certification:	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28b. Injury at Work? 2 Accident 28c. Injury at Work? 1 Yes 2 No											
To the Hospital or Attends within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Certifi	3 Sulcide 6 Could not be determined	28e. Place of Inj building, et	jury - At hor c. (Specify	me, ferm, stre	et, factory, office		28f. Location City or Te	(Street end Num own, State)	ber or Rura	l Route Number,		
the Hospital or hin 24 hours after the Funeral Div nplotely filled in	edical	29e. Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best liner: On the basis of end manner st	f examinati	viedge, deeth ion and/or Inve	occurred at the ti estigation, in my	me, date and ple opinion, death o	ece, and due to the courred at the time	e cause(s) and m , dete and place	anner as st , and due to	tated. the cause(s)		
To Table	2	29b. Signeture and title of certifier	1		- 0	29c. Licen			29d. Dete sign				
J.		30. Name and address of person who	CONTRACTOR OF THE CONTRACTOR O	L leath (Item	23a) (Type 5	2rint)	0183	52	MAY	11,	1499 W2078		
		2	The second second	A A	Lou, (Type, P	7		0 1 1 1			Car A.		



ITE	M: #8 PE	ER F.H. G77	1 5-28-99 WR			epartment of referrificate of			ig. No.	1/	164		
(i)	Physician	11/2011	eme (First, Middle, La					2. Dete of Death Month		Year	3. Time of Death		
	/Medical Examiner	An English, Name // and Institution also stood and are built					4b. City, Town, or L		4c. County		11.20/11		
<b>1</b>		Holy (	Cross Hosp	Silver S	Spring	Mon	tgome	rv					
	uneral irector	5. Social Security Number 6. Sex 1 Months Deys 1 1 M 2 F (4 Yrs. last birthday) Months Deys 1						8. Dete of Birth (Month, Dey,	e of Birth Noth, Dey, Year) 1935 9. Birthplace (State or Fore Country) rch 6, 1135 Jamaica, WI				
2		Usuel Residence		1.	10a City Town o	I continu			,	-			
aryte	ahou i	10a. Steta   10b. County   10c. City, Town or Location   Montgomery   Silver Spring								100	tnside City Limits  1 □YYes 2 □ No		
Me M	or 28e-fa	יווי		егу	2110						^		
ath with t	Nerne 23e or 28e-f show over must be normed at Tuneral Director	10e. Street and 2939	Schoolhou <sup>s</sup>	e Circie		10f. Zip Code 2090	)2		USA	Vhat Country	7		
5-0020 72 hours efter death with the Maryland	by F	11. Merital Stetu 1 Never M 3 Widowe		12. Was Decedent Ev Armed Forces? 1 Tyes 2/1 No If Yes, Give Yeer or Detes:	er in U,S.	3. Was Decedent of In If Yes, specify Cubin 1 ☐ Yes 2 ☐ No	tispenic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		Blace			
5-0 72 he	"natural", office Essisted by	/5	15. Decedent's Ed			cedent's Usual Occupive kind of work done		ino	16b. Kind of Bu	islness/Indu	stry		
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or the	frem 27 other tr	20e. Method of I	ine Mille Disposition 2 CXCremetion 3		20b. Plece of Di cemetery, o	39 Schoolh sposition (Neme of cremetary or other ple	ce)	Dete 20c. Location - City or			, State		
timen	ortant: injury	4 Donetic	n 5 Other (Specif	y)	Unesa	reake Crem	- +						
Balt Permit.	important: If any injury or poce.	21. Signeture of	Funeral Service Licer	1500	278	22. Neme and Addres	eorgia Av		Wash.,		20011		
Phy	sician	23a. Pert1. Ente shock, or t	er the disease, or com- neert failure. List only	plicetions thet caused the cone ceuse on eech line	ne deeth. Do not	enter the mode of dyir	ng, such as cardiac	or respiretory erre	est,	tr	pproximate iterval Between inset and Deeth		
/M	ledical aminer	immediete Ceus diseese or cond resulting in deal	lition		astatic ue to (or as a con	Breast C	ancer	1038	-	1	3 mos		
68760, ificate be executed	g physician and es the bunel-transit ledical Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Undertying Ceuse (Disease or Injury that initiated events resulting in death) Last  b. Due to (or es a consequenca of):  c											
Box (death certif	ed by the ettending p detached for use es	2 11 21		d									
P.O.	by the tached	Pert II. Other sig		ontributing to death but					id tobacco use contribute to the cause of death?  Yes 28 No 3 Probably 4 Unknown				
	50 0	Pull	nonary and	Bone M.	etastasc	5		24e. Wes er	n autopsy	24b. Were	autopsy findings		
e e c	page 2 should Completed							perform		of de	eth?		
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Vital	director,	examiner?	ferred to medical	Hospitel:	~	_ Ott	ner _	h (Check only one					
0 £	this ald di	1 ☐ Yes 2 27. Menner of D	No nath	1 ☐ Inpatient	2 ER/Outpa 28b. Tim	III JUA	4 Li Nursing Ho	ome 5 Reside					
L B	After	1 Neturel	5 Pending	(Month, Dey 1	rear) 200. Time	y Wo	k? Yes 2□No	200. Describe no	w injury occur	90			
Division or Attending after death.	To the Funeral Director: After th completely filled in by the funeral Medical Certification: 7	2 Acciden 3 Suicide 4 Homicid	6 Could not be	B 200 Place of Injur	/ - At home, ferm, (Specify)	street, fectory, office	165 2 140	28f. Location (Str City or Town	reet end Numb , State)	er or Rural F	Route Number,		
Di the Hospital or hin 24 hours afte	or the Funeral I impletely filled Medical Ce	29e. Certifier (Check only	1 Certifying Ph	yatcian: To the best of e	xeminetion and/or	eeth occurred et the tir	me, dete end place,	and due to the ca	use(s) and ma	nner as stat	ed. ne cause(s)		
thin 2	Med mple	Sinnatulera	ind title of certifier	and menner stete	d.	29c. Licens	a number	20	d. Date signe	1 (Month De	v Veerl		
Towiti	28	1		weagn			23743	25	May		999		
		30. Name and ed Martin	D. Weltz	completed cause of dee			Greenbelt	Md 2	.0770				
	State Registrar	31. Date filed (M	MAY 28	32. Registrar			Ki						



Please Type or Print in Biack Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 3. Tima of Death 2. Date of Death Month Yee **Physician** PHELPS FLORENCE 1999 MAY 25 /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL CENTER BALTIMORE HARBOR N/A If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Hours 1 ☐ M 2X F Months Days 240 28 6297 80 Director May 10, 1919 North Carolina Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. fnslda City Limits 28a-f show r than "natural", or flame 23a or 28a-f shov the Medical Examinar must be notified at Maryland Anne Arundel 1 ☐ Yas 2 No Glen Burnie Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with 842 Bentwillow Drive 21061 U.S. Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No 14. Raca - American Indian. 11. Maritai Status Black, White, etc. Peges 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. and If Item 27 is marked other than "natural", or feel any or other traumate event, the Medical Examinary or other traumate event, the Medical Examinary. 1 Navar Married 210 Married American Baltimore, Maryland 21215-0020 If Yes, Give Year or Datas: 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorcad Indian Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elamantary/Secondary (0-12) College (1-4or 5+) Teacher Substitute Teacher 2 years 17 Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) Carrie Baker McDuffie Cummings 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Wayne Phelps Husband 842 Bentwillow Drive Glen Burnie, Maryland 21061 20b. Placa of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or 5/29/99 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery Baltimore, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Gonce Funeral Home P.A. manuscur 4001 Ritchie Highway Baltimore, Md. 21225 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heer feilure. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Finel SEPSIS disease or condition resulting In death) Examiner Due to (or as a consequenca of) Examiner CANCER CELL LUNG physician and s the burial-transit certificate be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting In death) Last Physician/Medical Due to (or as a consequence of): signed by the a 23b. Dfd tobacco use contribute to the cause of deeth? P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Yes 2 No Division of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy Completed has 1 Yes 2 No 1 Yes 2 No certificate 25. Was case referred to medical Be 26. Place of Deeth (Check only one) exeminer? Othar: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Natural after death. Director: Aft 1 Yes 2 Accidant 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 6 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) To the To To the To and manner stated. 29c. Licansa number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifian 25 h 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL CENTER, BALTIMORE, MP-21225 MOGHEKAR HARBOR

ar)

32. Registrer's Signature

State **DHMH 16 Rev 6/95** 

Registrar

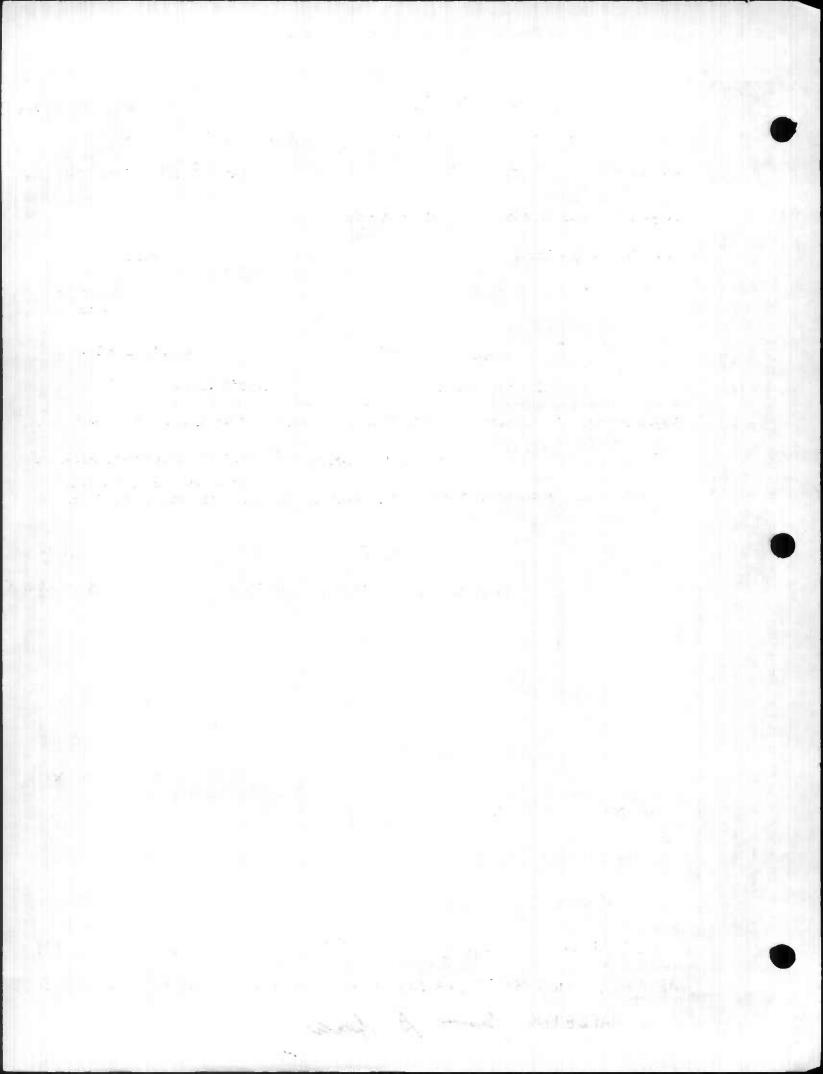
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MAY 2 8 1999

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31. Dete filed (Month, Dey, Year)

D. Sports



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Month Veer D Anna May 27 1999 /Medical 12:30 am 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Stella Maris Towson Baltimore If Under 1 Yeer | if Under 24 Hrs. 5. Sociel Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** Days Hours 1 ☐ M 2 💢 F Director 219-30-2524 86 Yrs. August 29, 1912 Ohio Usuel Residence of Decedent with the Maryland 10a State 10h Count 10c. City, Town or Location 10d. inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, its Medical Examiner must be notified at Director Maryland Baltimore 1 Yes 2 No Cockevsville 10f. Zip Code 10e. Street end Number 10g. Citizen of What Country? 10861 Sandringham Rd. 21030 U.S.A. deeth Funeral 12. Was Decedenf Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specify: White 3 XWidowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 6 yr's Seamstress Clothing permit. Pages 1 and 2 should be filed Department of Health and Mental Hygic Important: If Item ZT is marked other any Injury or other traumatic avers. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Constantine **Thomakos** Panayiota Strilakos ပ 19a. fnforment's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Samuel D. Poulos -Same as #10 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) Greek Cemetery 5/29/99 Baltimore, MD Harrtsock. Jr. 22. Name end Address of Fecility Paul L. Baltimore, MD Leonard J. Ruck, Inc. 5305 Harford Rd. 23a. Pert1. Enter the disease, or complications that crused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heart failure. List only one ceusing a gach line. Approximete interval Between Onsei end Death **Physician** /Medicai Immediate Cause (Final disease or condition resulting in deeth) MYOCARDIAL INFARCTION Examiner Due to (or as e consequence of): Examiner burial-transi Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of) nding physician a use es the burial-Box 68760 Physician/Medical Due to (or es e consequence of): atten Por Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. P.O. 23b. Did tobacco use contributa to the cause of death? the signed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown þ should be Completed 24e. Wes an eutopsy performed? 24b. Were autopsy findings aveileble prior fo completion of ceuse of death? has 1 ☐ Yes 2 No certificata 1 ☐ Yes 2 ☐ No Vital Be 25. Wes cese referred to medical examiner? 26. Plece of Deeth (Check only one) Other: Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA ot After this funeral 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth edical Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Division Weture 5 Pending investigation To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: Al completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide \*\*Certifying Phyeician: To the best of my knowledge, death occurred et the time, date end plece, and due to the ceuse(s) and menner as stated.

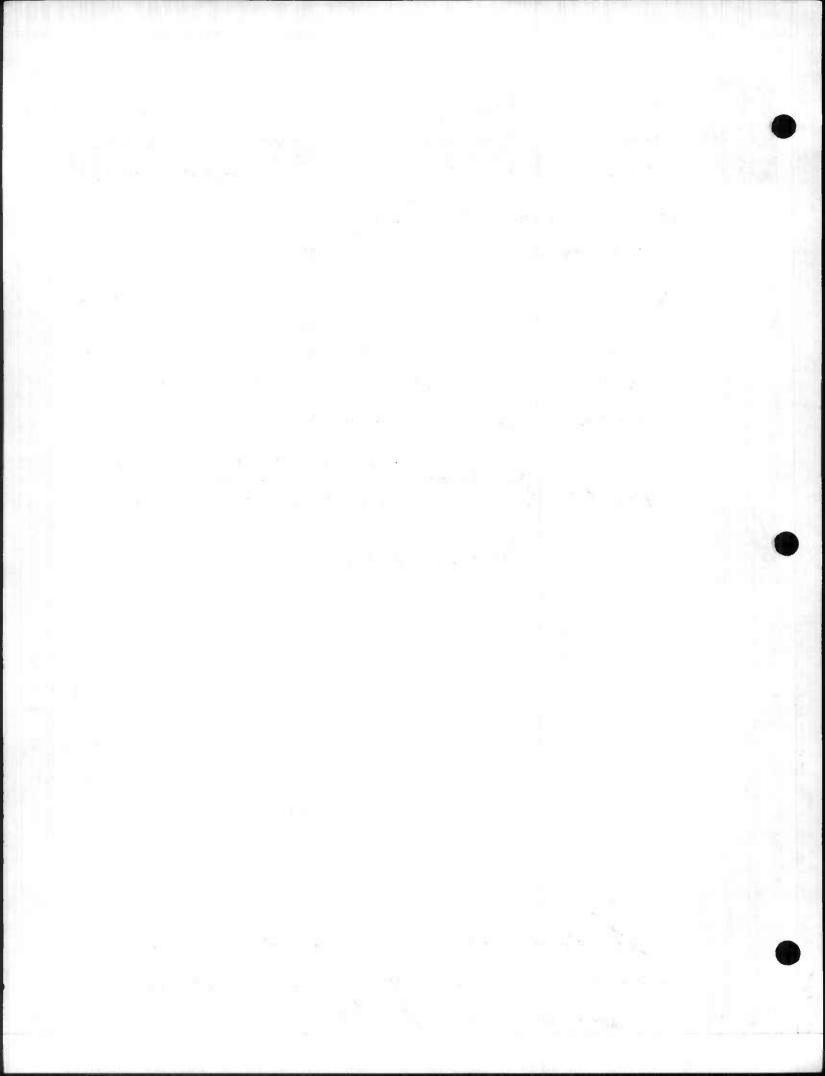
2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end plece, and due to the cause(s) end menner stated. 29a. Certifier (Check only one) of certifier 29b. Signature end. 29c. License number 29d. Dete signed (Month, Day, Year) SERESI D 15504 5.22.88. 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Eddie Nakhuda, M.D. 2300 Dulaney Valley Rd Timonium, Md 21093 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State Registrar MAY 28 1999

ANNA

POULOS

NAME

**DHMH 16 Ray 6/95** 



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Day 1999 Year Month MARION POWELL JR. May 25 1945 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Balto City Balto City If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foreign Days Months Hours 212-40-3551 15M 20 F Georgia 55 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Balto. Co. 1 Yes 21 No Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8120 Dales Ford Rd 21234 USA Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forces? 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 Nevar Married 2 Married 1 Yas 2 No White 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☑ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Self-employed 9th 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First Middle Maiden Sumame) Jarriel Marion Powell Sr. Maudie 19a. Intormant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph L Powell Sr. (son) 8120 Dales Ford Rd Parkville, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Burlal 2 ☐ Cremation 3 ☐ Removal from State May28 1999 Middle River, MD 4 Donation 5 Other (Specify) Holly Hill Cemetery 21. Signature of Fundal Staylor Licensee
Dean P Charlton 22. Nama and Addrass of Facility 2007 Eastern Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death efferentialel carcino Immediate Cause (Final MUNTYI disease or condition resulting in death) Sequentially tist conditions, if any, leeding to immediate cause. Enter Undarfying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 Yas 2 No 25. Was case reterred to medical 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 2 Accident 5 Pending invastigation 1□Yas 2□No

that the death certificate be asscuted P.O. Box 68760 Division of Vital Records, or Attending Physician: The lew **Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

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To

Examiner

Physician/Medical

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Completed

Be

Certification: To

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**Funeral** 

Director

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28a-f

Barrie 23s or

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Hygiene.

Important: If them 27 is marked on any injury or other traumatic aver once.

**Physician** 

/Medical

**Examiner** 

physician and the burial-transit

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24 hours after deel Funeral Director:

within 24 ho To the Fune completely fi

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filled in !

hours after

Pages 1 and 2 should be

altimore, Maryland 21215-0020

**DHMH 16 Rev 6/95** 

State Registrar

31. Date filed (Month, Day, Year) / MAY. 28 1999

3 Suicide

29e. Certifier

MICHARL

4 T Homicide

(Check only one)

29b. Signature and title of certifier

6 Could not be determined

TULIE 11

30. Nama and address of person who completed ca JHBVML

se of deeth (Item 23a) (Type, Print) 4940 ENFER

🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steted.

29c. License number

29d. Date signed (Month, Day, Year)

281. Location (Street and Number or Rural Route Number, City or Town, State)

BALTIMERE, Md

32. Registrar's Signature

28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify)

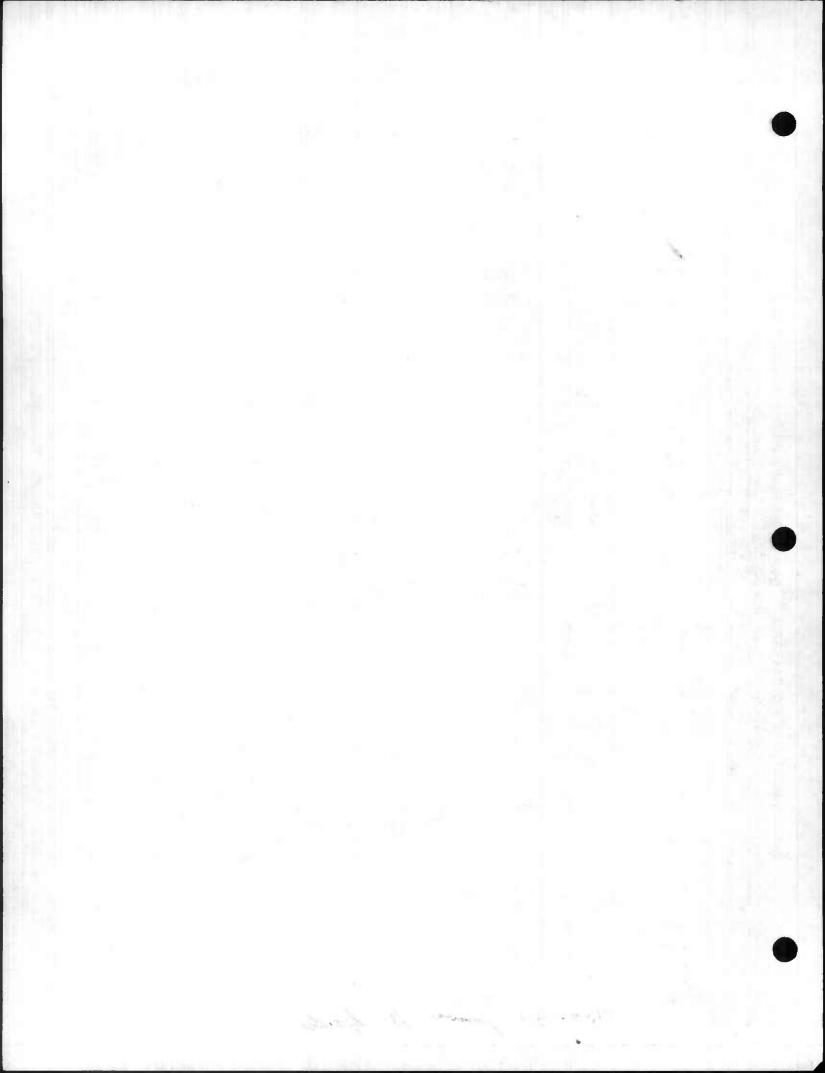
137 28 1993 See N. Janes

### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death Month Year Am **Physician** POWELL LAURA 99 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GIREEN, 115 E. MELROSE BALTIMORE GENESIS LONG If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (Steta or Foraign
Country) **Funeral** 1□ M 2 F 17-22-940 Director 10d. Inside City Limits 10c. City, Town or Location 28a-f show Vas 2 No Director mo MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 WisA1 "natural", or Items 23a Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?
1 Yas 2 No
If Yas, Give
Yeer or Detas: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 Nevar Married 2 Merried 1 Yas 20 No Baltimore, Maryland 21215-0020 by ALK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) permit. Peges 1 and 2 should be filed within Department of Heelth and Mental Hygiene. Important: if flem 27 is merked other than any Injury or other traumatic avant Elemantary/Secondary (0-12) College (1-4or 5+) NIA Home proken NA 17. Fathar's Name (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Be WIKS John NANCY Chapman 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) Linwood Ave 3410, mQ. 20b. Place of Disposition (Nama of cemetery, cramatory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Stata Buriel 2 Cremetion 3 Ramovel from State
Donation 5 Other (Specify) nto. nd 21. Signatura of Funaral Sarvice Licensee al 5 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata tntarval Between Onset and Death **Physician** BREAST CANCER /Medical Immediata Causa (Final METASTATIC diseasa or condition resulting in death) Examiner PARA PLEGIA Examiner physician and the burial-transit Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disaase or injury that initiated evants resulting in death) Last Box 68760 Physician/Medical Dua to (or es a consequence of): P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed 1 Yes 2 No 1 Yas 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I 25. Was case referred to medical axaminar?
1 Yes 2 No Be 26. Place of Deeth (Check only one) Hospital: Other: Certification: To Nursing Home 5 Residence 6 Other (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Menner of Death
1 Accident 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 5 Pending invastigation 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) BNLTO; md 1 6 Could not be datarmined 3 ☐ Suicida 28a. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida edical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

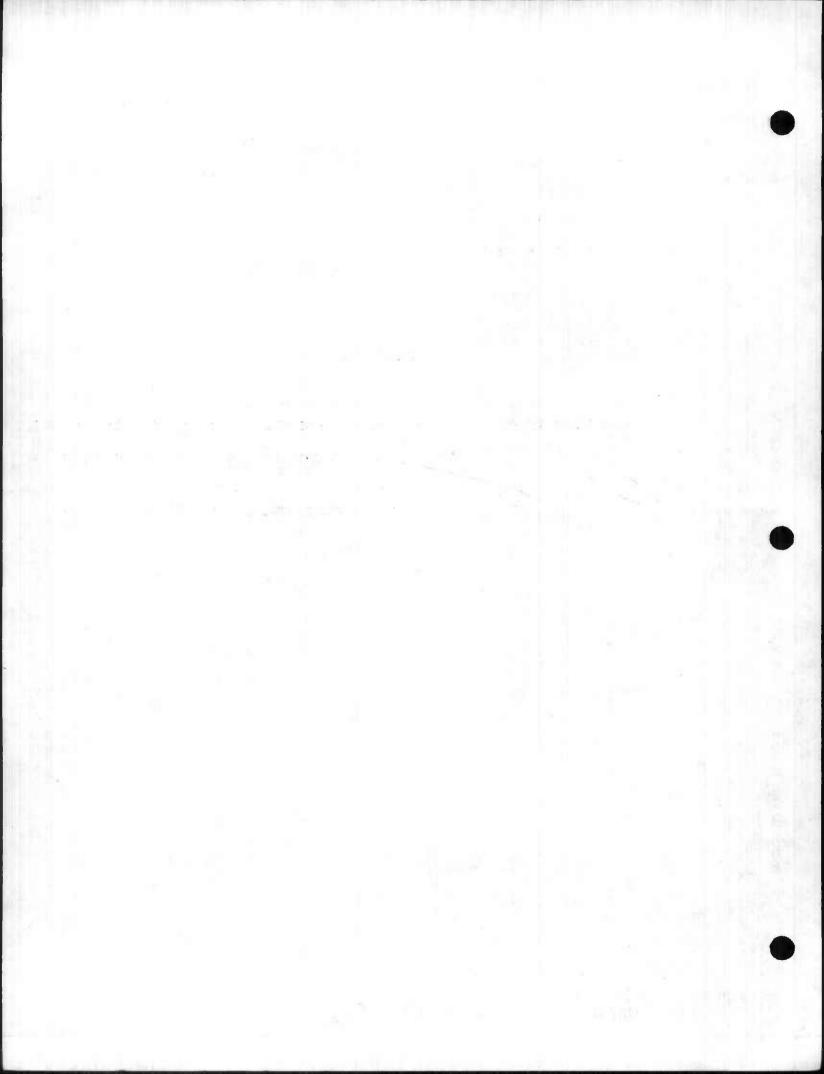
Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one) 29b. Signatura and title of certifier 29d. Data signed (Month, Day, Year) 29c. License number Kanymond A'Mzem 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)
RAYMOND A'NZEMN PA. 7Q01 VC Towson MD21204 A. NZE MD PA, 7801 YORK RD #100, 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State Registrar MAY 2 8 1999



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Dhualalan	1. Decedent's Nama (First, Middle, Last)	2. Data of D Month	leath Day Year	3. Time of Death		
Physician /Medical	CHARLES O PLATT	MAY	26 1999	5 AM		
Examiner	4a Facility Nama (If not institution, giva street and number)	b. City, Town, or Location of Dea	th 4c. County of Deat	h		
	LEVINDALE	BALTIMORE If Under 24 Hrs.   8 Data of B	N/A			
Funeral Director	5. Social Security Number 216–24–5024 6. Sex 7. Aga (In yrs. last birthday) 1 Vinder 1 Year Months Days	Hours Min. (Month, C	Day, Year) Co	hplaca (Stata or Fora buntry) RYLAND		
show stat	Usual Rasidanca of Decedant  10a. Stata 10b. County 10c. City, Town or Location			10d. Inside City Lim		
me 23e or 28e-f show crust be nothed at neral Director	MD BALTIMORE OWINGS MILLS			Y Yas 2□N		
or 28a-f	10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	untry?		
23a	4408 SILVERBROOK LA., K-201 21:	117	USA			
h, or he by Fu	11. Marital Status  1 Nevar Married  1 Nevar Married  2 Married  1 Nevar Married  3 Widowed  1 Divorced  12. Was Decedent Evar in U,S. Armed Forcas?  1 Nevar Married  13. Was Decedent of His If Yas, specify Cubar  1 Yas, Siva  Yaar or Datas:	spanic Origin? (Specify Yas or N n, Mexican, Puarto Rican, atc.) Specify:				
yglene. wr than "naturn rt, me tradical Completed	15. Decedent's Education (Specify only highast grada completed)  [Secondary (5) 200 College (1,405 5)]  [Secondary (1,405 5)]	uring most of working	16b. Kind of Businass/	Industry		
Hyglene. other than ent, the M	Elemantary/Secondary (0-12) College (1-4or 5+)  12 OWNER		RECORD	STORE		
marked other uradic event, To Be Co		18. Mothar's Nama (First, Middl	la, Maiden Sumama)			
Mental mrked o etic ev	HARRY	HILDA	GOLDBERG			
th and Mer 7 is marke traumatic	2 20,142	and Number or Rural Routa Num	ber, City or Town, Stata, a	Zip Code)		
nent of Heal ant: If item 2 arry or other	20a. Mathod of Disposition  1 ⊠ Burial 2 □ Cramation 3 □ Ramoval from State  4 □ Donation 5 □ Other (Specify)  20b. Place of Disposition (Nama of camatary, cramatory or other place LIBERTY PARK SHAAI	REI ZION CONG.	OWINGS MIL 20c. Location - City or RANDALLSTO			
Depart Importu any Inju	21. Signature of Funaral Service Licenses 22. Nama and Address SOL LEVINS  23a. Part 1. Enter the disease, or complications that caused the death. Do not sale on the caused the death. Do not sale on the caused the death.	SON & BROS., INC				
ta has been signed by the ettending physician and page 2 should be detached for usa as the burial-transit or completed by Physician/Medical Examiner	in medical actual (ritial disease or condition rasulting in death)  Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants rasulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	-doffise		Years		
e ettending   ed for usa as siclan/Me	d Part UnOther algnificant conditions contributing to death but not resulting in the underlying cause give	n in Part I. 23b. Di	d tobacco use contribute	to the cause of dea		
igned by the be detached by Physic	Cerebrovasion disease penpresal	10	1 Yea 2 No 3 Probably 4 U			
ata has been signed by the ettending, page 2 should be detached for usa.	Cerebrovasion diseases penpresal	24a. Wa	formed?	Wara autopsy finding available prior to completion of causa of death?		
page Com		10	Yas ZINO	1 ☐ Yas 2 ☐ No		
	25. Was casa rafarred to medical	26. Placa of Death (Check only	ona)			
er this seral di	Accident investigation  Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other    1   Yas 2   Tho   Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other    27. Manager of Death   28a. Data of Injury   28b. Tima of   Injury   Work    28c. Injury   Work   Thopping   28c. Injury   28c. Injury   1   1   1   1   1   1   1   1   1	41/2 Nursing Homa 5 Ha	sidence 6 Other (Spe	city)		
within 24 hours after death. To the Euneral Director: After the completely filled in by the funeral Medical Certification:	2 Accident investigation 3 Sulcide 6 Could not be datarmined 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify)	28f. Location	(Street and Number or Ri own, State)	ura i Routa Number,		
n 24 houn e Funera sletely fille	29a. Cartiflar (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time (Check only one)  Medical Examiner: On the basis of examination and/or invastigation, in my op and mannar sta	e, data and place, and dua to the inion, daath occurred at tha time	a causa(s) and mannar as a, data and ptace, and due	s stated. a to the cause(s)		
To the comp	29b. Signature and title of certifier  29c. License	3543	29d. Date signed (Mont	h, Day, Year)		
	30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)	1				



State of Maryla	and / Department of	of Health and	Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3 Time of Death Month Day Yaar Perlman **Physician** Harry 1999 MAY 25 12:45 am /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Undar 1 Yaar If Undar 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) 8. Data of Birth (Month, Day, Year) **Funeral** Hours XOM 20F Months Days Yrs. 79 Director 119-10-8875 NEW YORK Usual Rasidança of Decedent Pages 1 and 2 should be filed within 72 hours aftar death with the Maryland sent of Health end Mental Hygiene.

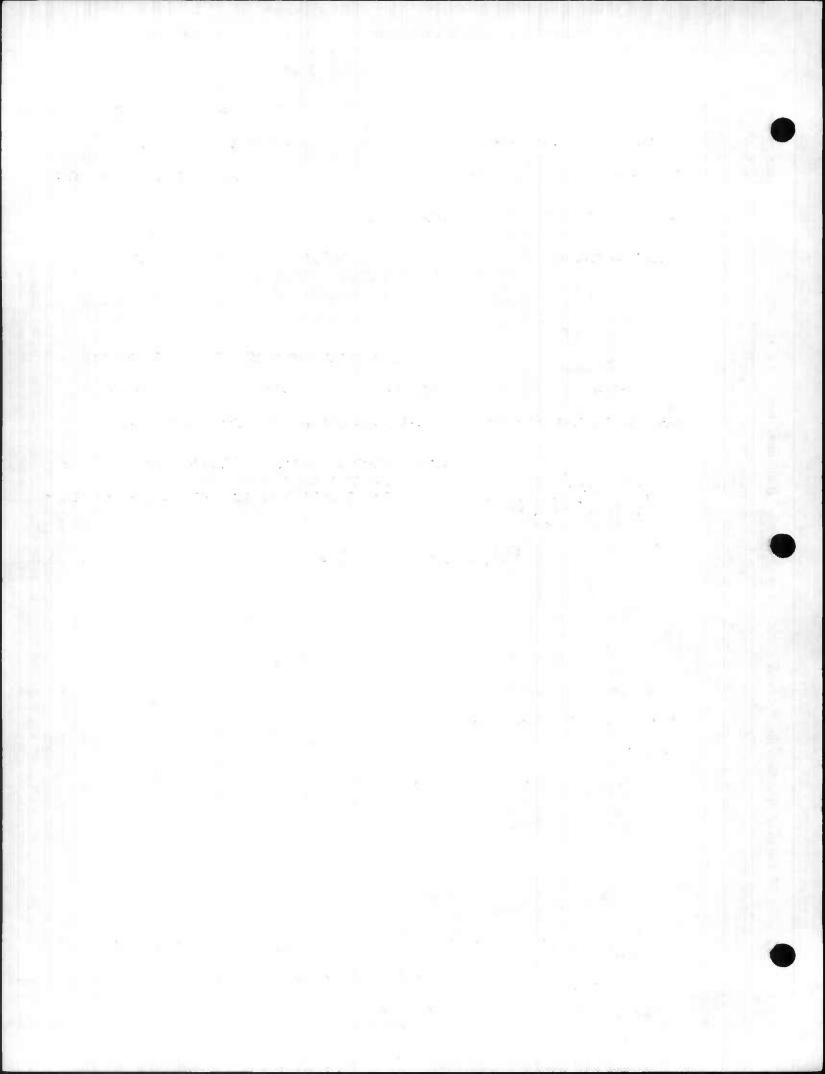
It is fam 27 is marked other than "natural", or items 23s or 28s-f ehow 10a. Stata 10c. City. Town or Location 10b. County 10d. Insida City Limits "natural", or items 23a or 28a-f ehow edical Examiner must be notified at 1 Yas 2 No CARROLL **ELDERSBURG** Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 5922 OKLAHOMA RD 21784 Funeral USA 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 14. Race - American Indian, Black, Whita, atc. 11. Marital Status Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 Navar Married 30 Married 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE by 3 Widowed 4 Divorced h and Mental Hygiene.
7 is marked other than "natur traumatic event, on Medical. Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collage (1-4or 5+) 12 ELECTRONIC REPAIRMAN ELECTRONICS 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Sumama) Be JOSEPH PERLMAN IDA UNKNOWN 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) MRS. GLADYS PERLMAN (WIFE) 5922 OKLAHOMA RD. ELDERSBURG, MD 21784 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata permit. Pages Department of Important: If it any injury or or 4 ☐ Donetion 5 ☐ Othar (Specify) AGUDAS ACHIM ANSHE SFARD 5/27/99 ROSEDALE, MD SOLE LEVINSON Facility BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208 alions thet causad tha daath. Do not antar tha mode of dylng, such as cardiac or respiratory arrest, one couse on each line. Approximata Intarval Batween Onset and Death **Physician** /Medicai Immediate Cause (Final disaasa or condition resulting in deeth) 2 WKS Examiner Examiner and The law requires that the death certificate be axecuted Sequantially list conditions, if any, leading to immadiata causa. Enter Underlying Causa (Disaasa or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of) physician ar s the bunal-t Division of Vital Records, P.O. Box 68760. Physician/Medical Dua to (or as a consequence of) as USB Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performad? Completed Hypotensian Accident Vascular 1 Yas 2 No 1 Yas 2 No Corcbral or Attanding Physician: 25. Was casa rafarrad to medical axaminar? Be 26. Placa of Death (Check only ona) Hospitel: 1 finpatient 2 ER/Outpatient 3 DOA To Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? 5 Panding Invastigation 1 Natural after death. 2 Accident 1 Yas 2 No 6 Could not be datamined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) In 24 hour. 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred et tha tima, data and place, and due to the cause(s) and mannar as steted.
2 Medicat Examinar: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. 29a. Certifian Wedical completaly (Check only one) within 2 the th 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Date signed (Month, Day, Year) RES - 000 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

Derek Taylor MD Johns Hopkins Hospital 1830 E. Monument St. Rm 9020 Bult. MD 21205 Taylor Derek 31. Dete filed (Month, Day, Yaar) 32. Ragistrar's Signatura State MAY 2 8 1999

parker

**DHMH 16 Rev 6/95** 

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Nema (First, Middla, Last) 2 Dete of Death 3. Time of Death Month **Physician** Keynolds rancis 08:24 AM 26 1999 May /Medical 4a Eacility Nama (If not institution, giva street and number, 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Baltimore
If Undar 24 Hrs. 8. Dete of Social Sacurity Number 7. Age (In yrs. last birthdey) Yrs. If Under 1 Yaar 6. Sax 8. Dete of Birth (Month Dey, 9. Birthplace (Stete or Fpreign **Funeral** 18-014 1₩ 2□ F Months Deys Hours Min. Director Usuel Residence of Decadent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Baltimore 1 Yas 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2122 ed permit. Pages 1 and 2 should be filed within 72 hours aftar death 1 Department of Haelth and Mental Hydiana. Important: If item 27 is marked other than "natural; or items 23a any hijury or other traumatic event, the Heddal Examiner must once. Funeral 14. Rece - American Indier 12. Was Decedant Ever in U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status Bieck, White, etc. 1 Never Merried 2 Married 1 Yes 2 No If Yas, Give Year or Datas: 1 Yes 2 No Baltimore, Maryland 21215-0020 Specify: by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada completed) Elementery/Secondary (0-12) College (1-4or 5+) 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Lest) Catherine ohn oloseoh N7G 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 5655 69 th St. Vero Beach FL 329 Christopher 20a. Method of Disposition Keynolds/301 5655 20b. Place of Disposition (Nama of cometery, frametory or other place)

Mead Dwridge Memorial Data 20c. Location - City or Towo, Stete 1 Deurial 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Lansdowne 2719 Hammon's Ferrurd. Battom Dol 227 Pert1. Enter tha diseasa, or complications that caused tha death. Do not anter tha mode of dying, such es cardiac or raspiratory arrest, shock, or heart feiture. List only one cause on each line. Approximete Intarval Batween Onset end Deeth **Physician** Immedieta Ceuse (Final diseese or condition resulting in deeth) /Medical PALUMONIA Week Examiner Dua to (or es e consaquence of) Examiner D475 Failure physician and the bunal-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disaase or Injury that Initieted eventa resulting in deeth) Lest Due to (or es e consaguence of): Pulmonory discuse Chronic operhappe Veur 5 Physician/Medical Due to (or es e consequenca of): DECP 2 Days thrombosus Venous usa Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 2 No 3 Probably 4 Unknown 1 Yes prosure, COMMA William Reymolds þ 24b. Wara autopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed hyperlipidemia after death.

Director: After this cartificate has 2 No 1 Yas 2 No 25. Wes case referred to medical examinar? Be 26. Piece of Deeth (Check only one) 1 Yes 2 No Hospitel: Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) Certification: To Inpatiant 2□ER/Outpatient 3□ DOA 27. Mannar of Deeth 28b. Tima of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Natural
2 Accidant 5 Panding Investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 28f. Location (Street and Number or Rurel Routa Number, City or Town, Stete) 4 Homicide To the Hospital c within 24 hours at To the Funeral Di Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end dua to the causa(s) and menner as stated.

Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier Medical (Check only one) 29b. Signeture and title of certifier 29c. Licensa number 29d. Dete signed (Month, Dey, Year) P12590 26,1999 House officer 30. Neme end eddress of person who complated causa of daath (Itam 23a) (Type, Print) Baltimore City, Morriand 900 FLINSTEIN, NO lapon AVEAUL 32. Registrer's Signeture Registrar DHMH 16 Rev 6/95

Andrew Control of the the many state of the state of

AMEND ITEM#18 PER F.H. G772 6-18-99 J.A.

### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of H

2 Date of Death			1 0	49**		-
Death Reg. No.	2.2	Ł	i	1	U	La
Health and Mental Hygiene	0.0	1	7	1	2	2

Lowall R	inggold ITEM's #10E PER F.H. G771 5-28-99 WR Certificate of Death  1. Decedent's Name (First, Middle, Last)	Reg. No.	3. Time of Death
Physician		Month Day	Year S. Time or Death
/Medica	Lowall T. Ringgold	MAY 22,	1999 1658 PM
Examine			County of Death
		MORE CITY	N/A
Funeral Director	5. Social Security Number 213-04-3632 6. Sex 31 Yrs. Social Security Number 213-04-3632 7. Age (In yrs. last birthday) 1 H Under 1 Year 1 H Under 24 Hours 1 Months 1 Days 1 Hours 1 Months 1 Days 2 Hours 2 Months 2 Month	Ain. (Month, Day, Year)	9. Birthplaca (Stata or Foreign Country) New York
Pu *	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
vith the Maryli or 28a-f eho			1 🖄 Yas 2 🗆 No
P 28	10e. Street and Number 3617 GLENGYLE AVE.	10g. Citize	en of What Country?
Sa o	3617 Clengule Ave 21215	U	.S.A.
21215-0020  d within 72 hours efter deeth with the Maryland glere. It then "natural", or frems 23a or 28s-f show, the Maridal Everyfrer must be notified at	Armed Forces?  1 Never Married 2 XMarried  1 Yes 2 No  If Yes, specify Cuban, Mexican, Property		A. Race - American Indian, Black, Whita, atc. Specify: Black
5-002		16b. Kind	d of Business/Industry
	(Specify only highest grade completed) (Giva kind of work done during most of life. DO NOT use retired)	working	
d 2121 filed within Hyglene. ther then ont, me to	Elementary/Secondary (0-12)   College (1-4or5+)   Lube Technician		for Lubo
D BEEF			fy Lube
⊆ 83 P ≥ 0	10. Model of the control of the cont	Name (First, Middle, Maiden S	urramay
aryia ehould ind Men ind Men	Wallace Ringgold Louis	Simms	
2 end	19a. Informent's Neme/Ralationship (Type, Print)  19b. Mailing Addrass (Street and Number of	r Rural Route Number, City or	Town, State, Zip Code)
2 9515	Mr & Mrs W. Ringgold-Parents 3617 Glengyle A	Ave, Baltimo	re Md 21215
0 50 = 2	20a. Mathod of Disposition  1 Burial 2 Cremation 3 Removal from Stata  4 Donation 5 Other (Specify)  20b. Place of Disposition (Nama of cematary, crematory or other place)  **Email Removal from Stata**  **Incrematory or other place)		ation - City or Town, Steta allstown, MD
Baitim pemit. Pag Department Important: I	21 Signature of Fundral Service Licensee King Memorial Park 22. Name and Address of Facility	0/1/99   Kallu	alistown, mb
B F F F F F F F F F F F F F F F F F F F			
	230 Part 1. Enfer the disease, or completations that caused the death. Do not entar the mode of dying, such as can shock, or heart failure. List only one cause on each line.	ve, Baltimor	e Md 21215
Physician /Medical Examiner	Immediata Causa (Final disease or condition rasulting in death)  a. Multiple Gruns  bue to (br as disease or).	hot W	Occura S
death certificate be executed eletending physician and od for use as the buriel-transit			.
difficate be expensed by the purification of t	Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):		
E 90	Todaling in Golding Last		
BOX eath cert ettendin for use	d		
d for the dist	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.	22h Did tehanan u	se contribute to the cause of death?
P.O. del by the detech			No 3 Probably 4 Unknown
ew requi		24a. Was an autops performed?	24b. Were autopsy findings available prior to completion of causa of death?
The iev ate hes page 2		1 X Yes 2 □	No 10 Yas 2□ No
VITALI iclen: The certificate rector, pag	or many and the second		14,100 2010
Of VIta Physician: this cartific rai director.	examiner? Hospital: Other	Death (Check only one)	
A SE F	1 Inpatient 2 ER/Outpatient 3CXDOA 4 Nursin	ng Home 5 Residence 6	
Mending death. ctor: After y the fune	27. Manner of Death  1 Natural  2 Accident  3 Suicide  4 Momicide  28a. Date of Injury  28b. Time of Four 28d Injury at finjury  4 Now, 28b. Time of Four 28d Injury at finjury  4 Now, 28b. Time of Four 28d Injury at finjury  4 Now, 28b. Time of Four 28d Injury at finjury  4 Now, 28b. Time of Four 28d Injury at finjury  4 Now, 28b. Time of Four 28d Injury at finjury at finjury at home, finjury at finjury	28d. Describe how injury  Supplemental Street and City or Town, State)	t Shot Number or Rural Route Number,
To the Hospital or A within 24 hours effer To the Funeral Dire completely filled in b Martical Certi			
the spie			
To the within To the compile	29b. Signature and title of certifies  29c. License number  CCME		signed (Month, Day, Year) AY 23, 1999
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  111 Penn Street, Ba	ltimore, Maryl	and 21201
State	31. Data filed (Mont). Day, Year)- 32. Registrar's Signetura		

Registrar

titus per e

FUNERAL HOME GAVE CORRECTION SHEET WITH WRONG INFORMATION .

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q

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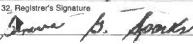
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Physicia	an	1. Decedent's Ne											2. Dete of De Month	Dey	Yeer		ime of Death
/Medic		4e. Facility Name			nd number	1				-	h City To	um orl	May 2 catton of Deat	2, 199			:20 pm
Examin	er														inty of Death	•	
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# # P	Director	10e. Street and N	lumber					1	Of. Zip Co	de				10g. Citizen	of What Cor	untry?	
end 2 should be filed within 72 hours effer deeth with the Marylend alth and Mental Hygiene. n 27 Is marked other than "natural", or items 23s or 28s-f show yer trsumstic svent, the Medical Examiner must be notified at		6800 Li	berty R	oad					2.1	20	7			US	A		
deep and	Funeral	11. Maritel Stetus		12. Was	Decedent		,S.	13. Was				gin? (Sp	ecify Yas or No Rican, etc.)		Race - Amer		llan,
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permit. Pages 1 and 2 should be filled within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, tra Medical Exa		20e. Mathod of Di	sposition 2 Cremetion	3   Removal	from State	20b. F	emelery	cremato	n (Nema a	or r plec	e)	į	Data	20c. Locati	on - City or 1	own, St	ate
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partition y in	1	21. Signature of F	Funeral Service	Licenyee	01			22. Na	me end A	ddres	s of Fecilit	ty					
Depa Impo any is		D/ L	rolli.	AV 1	han	1	-						ne, Inc , Balt				21222
Physician /Medical		Immediate Cause disease or condit	eert failure. List	only one ceus	that cause on each I	ine.		ot enter th	na mode o							Appro Interv Onse	oximata val Between t and Deeth
Examiner		resulting in deeth	)	a				onsequen				_					iours
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Attending Physician: or deeth. ector: After this certific by the funeral director.	ation:	27. Menner of Dec 1 ☑Naturel 2 ☐ Accident	eth 5 ☐ Pendir Investi	ig .	Date of Inju (Month, Da	iry (y Year)	28b. Ti Inj	iury	28c.	Injury Work	rat <br Yes 2□	No	28d. Describe	how Injury or	curred		
	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	ined 288.	Placa of In building, e			n, street,	factory, of	ffica			28f. Location ( City or To	(Street end Newn, Stete)	umber or Ru	ral Rout	e Number,
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State Registrar

31. Data filed (Month, Dey, Yper)

Thomas P. O'Brien, M.D.

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)



Sinai Hospital

2401 W. Belvedere Ave. Balto Md 21215

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

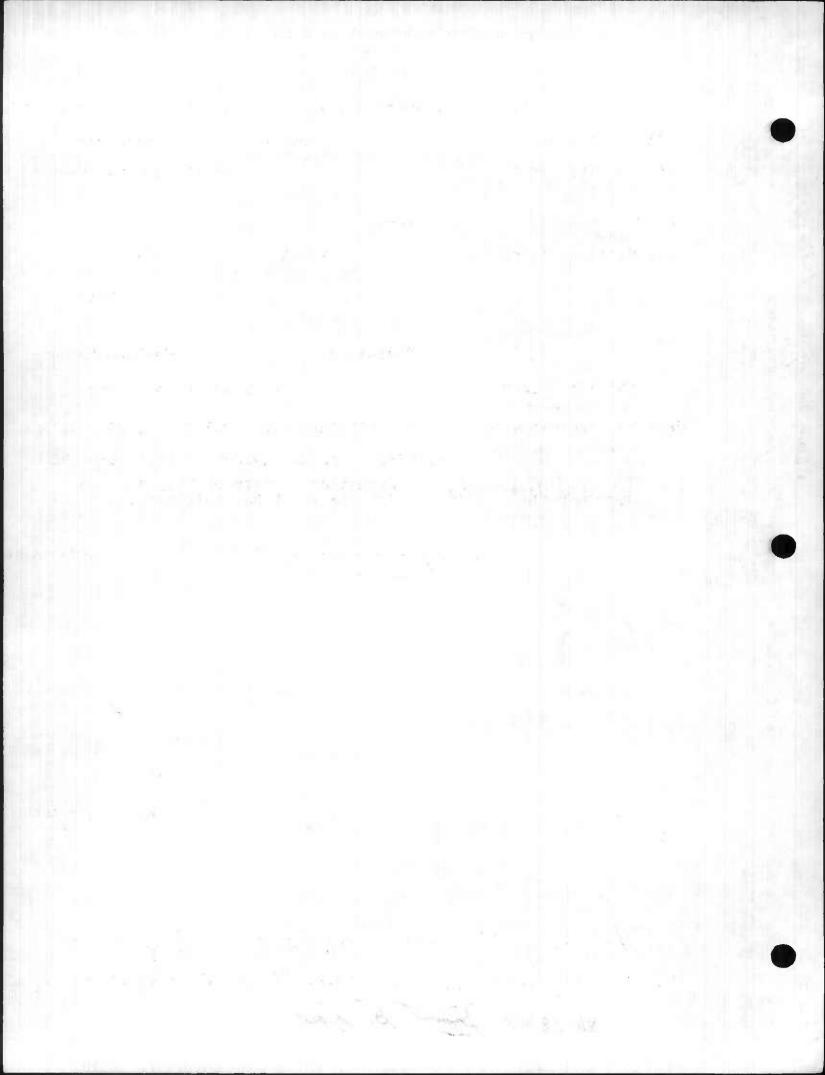
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Deeth Month Day **Physician** William Harvey Runciman, Jr. 26, May 1999 10:05 PM /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street end number) **Examiner** Gilchrist Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) JUNE 17, 1 5. Sociel Security Number Birthplace (State or Foreign Country) 7. Aga (In yrs. last birthday) **Funeral** 1 M 2 □ F Days Hours 099-50-1565 42 Yrs. 1956 New York Director Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "naturel", or thems 23s or 28s-f show traumatic event, the Woulds Examinating that be notified at X Yas 2 No Director MD N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 711 Gittings Avenue 21212 USA Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 20 No If Yas, Giva Year or Datas: 14. Race - American Indian Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Maxican, Puerto Rican, etc.) Black, Whita, atc. 1 Never Married 2 Marriad naturef, or [ Maryland 21215-0020 1 ☐ Yas 2 No Specify: White à 3 Widowed 4 Divorced 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada completed) filed within 7 I Hygiene. Collaga (1-4or 5+) Eiamantary/Secondary (0-12) Consultant Tele-Communications 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middle, Maiden Sumama) 2 should be f and Mental H is marked of William Harvey Runciman, Sr. Mary Louise Zielasko 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Peges 1 end 2 st Department of Heelth and Important: If Itam 27 is m any injury or other traum Jane M. Runciman/wife 711 Gittings Ave. Baltimore, MD 21212
Date 20c. Location - City or Town, Stata 20b. Place of Disposition (Nama of cematary, cramatory or other plece) Date 20a. Method of Disposition 1 ☐ Burial 2X Cramation 3 ☐ Ramoval from State Metro Crematory, Inc. 5/27/99 4 ☐ Donation 5 ☐ Othar (Specify) Baltimore, MD 21. Signetura of Funeral Sarvice biconsee Cremation Society of Maryland, Inc. Dawn F. McDonald 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset end Death **Physician** /Medical Immediata Cause (Finat diseese or condition rasulting in daath) 10 month Examiner Examine attending physician end for use as the buriel-trans Sequentially list conditions, if any, leading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiated events Dua to (or as a consequence of) Box 68760 certificate be Physician/Medical that initiated events resulting in death) Last Due to (or es e consequance of) 80 esn nse that the death 23b. Did tobacco use contribute to the cause of death? ed by the a Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by to 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Division of Vital Records, þ The law requires 24b. Wara autopsy lindings eveileble prior to 24a. Wes an autopsy Completed peen completion of cause of deeth? hes 1 ☐ Yas 2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: 25. Was casa referred to medical examinar? Be 26. Placa of Daath (Check only one) Othar: 4 Nursing Home 5 Rasidance 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 28d. Dascribe how Injury occurred 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? Certification: After t To the Hospital or Attending within 24 hours after deeth.

To the Funeral Director: Afte completely filled in by the fur 1 Natural 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datamined 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Ptace of tnjury - At homa, farm, streat, factory, office building, atc. (Specify) 4 ☐ Homicide edical 29a. Cartifiar 🗷 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to the cause(s) and mannar as stated. | Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signatura and title of certifia 29c. Licensa number 30. Nama and address of person who complated causa of death (Itam 23a) (Type, Print)

1. 1 A Riley GBm 6701 N. Chorles St., Belto. md 2120 X State Registrar

Runciman



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Deeth **Physician** POICK orothy 2025 24 /Medical 4a. Facility Nema (If not Institution, give streat and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Edgewater hoveham Kond BEACH If Under 4 Hrs. 8. Dete of Birth (Month, Day, If Under 1 Yeer 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) Days 1 ☐ M 2K F 80 165-18-0358 Yrs. 1919 Pennsylvania Usual Rasidance of Dacedant 10e, Steta 10b. County 10c. City, Town or Location 10d, insida City Limits Maryland Anne Arundel Edgewater 1 ☐ Yas 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 4176 Shoreham Beach Road 21037 USA Funeral 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yas, Giva Year or Datas: Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Raca - American Indian, Black, Whita, atc. 1 ☐ Naver Married 2 ☐ Married 1 ☐ Yas 2X No Specify: þ Specify: 3 ☑ Widowad 4 ☐ Divorced White Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Educetion (Specify only highest grada complated) 16b. Kind of Businass/Industry Elamentery/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middle, Maidan Sumama) George Denchy Patronella UNK. 19e. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Straat and Number or Rurel Routa Number, City or Town, State, Zip Code) William T. Ross/Nephew 6209 Riverland Run Centreville, VA 20120 20b. Placa of Disposition (Nema of camatary, cramatory or other place) 20c. Location - City or Town, Stata 1 ☐ Burial 2 🔀 Cramation 3 ☐ Ramoval from Stata Metro Crematory, 4 ☐ Donation 5 ☐ Other (Specify) Inc. 5/26/99 Baltimore, MD 21. Signature Funaral Sarvica Licensae 22. Nama and Addrass of Facility Cremation Society of MD, Inc. lu A 299 Frederick Road Baltimore, MD 21228 Edward Gregorchik 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or haen failure. List only one cause on each line. Approximata Interval Batween Onset and Death erioscleratic Heart Disease Immediate Causa (Final disease or condition rasulting in death) Examiner Sequantially list conditions, if any, laading to Immadiata cause. Entar Undarlying Ceuse (Diseasa or Injury that Initiated avents rasulting in deeth) Last Dua to (or as e consequence of): Physician/Medical Due to (or as a consaquenca of): Part il. Other significant conditiona contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Wera autopsy tindings available prior to complation of causa of death? Completed 24e. Wes en autopsy periormad? 1 Tyes 2 X No 1 ☐ Yas 2 ☐ No Be 25. Was casa rafarred to medical 26. Pleca of Death (Check only one) axaminar? Othar: 4 Nursing Homa 5 Aesidance 6 Othar (Specify) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yas 2□ No 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima ot 28c. Injury at Work? 28d. Dascribe how Injury occurred Certification: 5 Pending invastigation 1 Netural 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicida 6 ☐ Could not be datarmined 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) Location (Streat end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide 29a, Cartifier 1 Certifying Phyeician: To the best of my knowledga, death occurred at tha tima, date end place, and dua to tha cause(s) end mannar as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, deta and place, and dua to tha cause(s) Medical and mannar stated.

requires that the death certificete be execu Records, P.O. Box 68760 Division of Vital al or Attending P s efter death. I Director: After t To the Hospital o within 24 hours ef To the Funeral Di

**Funeral** 

Director

items 23s or 26s-f show incr must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Haalth and Mentai Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic evant, the Medical Examples

**Physiclan** /Medical

Examiner

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After this

filled in by the funeral

Baltimore, Maryland 21215-0020

deeth with the Meryland

State Registrar DHMH 16 Ray 6/95

31. Data filed (Month, Day, Year)

29b. Signatura end titla of certifier

MAY 28 1999

30. Name and address of person who completes causa of death (Item 23e) (Type, Print)

JONES, MM 32-Registrar's Signature

puty

29c. Licensa number

29d. Dete signed (Month, Day, Year)

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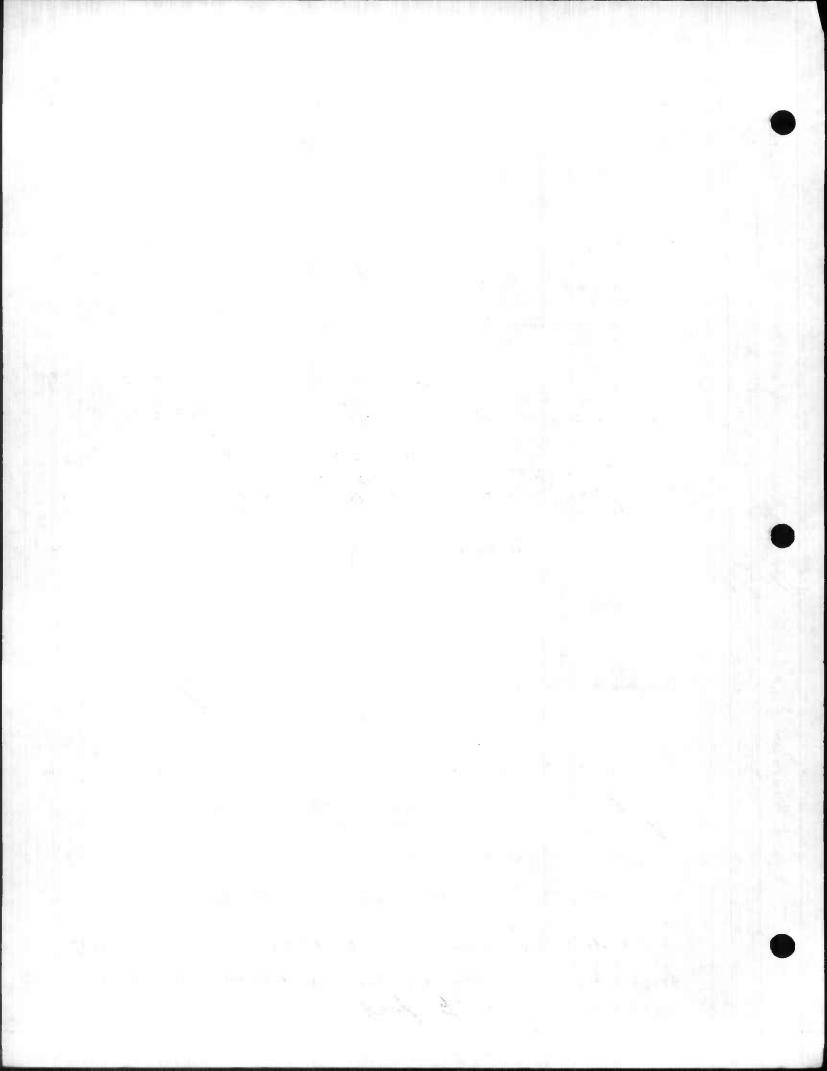
ITEMS: #23	PART I, 27, PER MEO G7		₹.	Cert	ificate o	of De	ath		Reg. No.			
Physician	1. Decedent's Name (First, Middle, L Terry Lynn Rust	ast)						2. Data of Da Month	Day	Year	3. Time of Death	
/Medical	4a Facility Nama (If not institution, g	ive street and numbe	arl			4b Ci	ity Town or	May 2 Location of Deat	1999 1 40 Court	y of Death	6:48 P.M	
Examiner	Anne Arundel Ger						Annapa			e Aru	indel	
Funeral	5. Social Security Number 6.	Sex 7. /	Age (In yrs. la	st birthday)	If Under 1 Yo	ear   If L	Jnder 24 Hrs.			_	lace (State or Foreign	
Director	221–38–7587	1□ M 20XF	46	Yrs.	Months Da	ays PK	ours Min.	8. Date of Bir (Month, Da Feb. 1	1953		aware	
2	Uaual Residence of Decedent  10e. Stata 10b. County		10c. City, Town or Location							1	Od. Inside City Limits	
with the Maryland a or 28a-f show the notified at Director	MD Anne A	runde1		apolis							1 ☐ Yes 2X No	
be notified	10e. Street and Number				10f. Zip Cod	de			10g. Citizen of	What Coun	itry?	
	776 F.Fairview	Avenue			214	403			USA			
y Funeral		Armed Forces	Armed Forces?			of Hispan Cuban, Me No Sp	exican, Puerl	pecify Yes or No o Rican, etc.)	es or No- 14. Race - American Indian,			
d by		Year or Dates	S:									
Completed	15. Decedent's I (Specify only highest g	rade completed)		(Give k	int's Usual Oc ind of work do O NOT use re	one durino		rking	16b. Kind of B			
mo	Elementary/Secondary (0-12)	College (1-4o	r 5+)	Promot:							County	
To Be C	17. Father's Name (First, Middle, Las	t)						na (First, Middle S Isaacs	, Maiden Sumai		az omeszo	
	19a. Informant's Name/Relationship							ıral Route Numb				
	Leroy L. & Phy11	is Rust (F					Avenu	e, Milfo				
	20a. Method of Disposition 1 ☐ Buriat 2 X Cremation 3	☐Removal from Stat	ie Cer	metery, crema	tion (Name of atory or other	place)	İ	Date	20c. Location	- City or To	wn, State	
1000	4 Donation 5 Other (Spec	ify)	Meti	co Crer				05/27	Baltimo	ore, N	1D	
	21. Signature of Funeral Service Finance  22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401											
ician dical niner	Immediata Cause (Final disease or condition resulting in death)	a. ATHEROS	CLEROTIC Due to (or	CARDIO		R DISE	EASE					
dical Examiner	Sequentially list conditions, if any, leading to immediate	b	Due to (or a	as a consequ	ence of):		-					
edical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	Due to (or a	a a conseque	ence of):					1		
2		d								-		
Physician/M	Part II. Other significant conditions	contributing to death	but not result	ing in the unc	lerlying cause	given in	Part I.	23b. Did	tobacco use co	ontribute to	the cause of death?	
by Phy								1   Yes 2   No 3   Pro			bebly 4 Onknown	
Completed									an autopsy ormed?	av.	era autopsy findings allable prior to mpletion of cause death?	
Con								162	es 2 No	16	Yas 2□ No	
8	25. Was case referred to medical examiner?	Manadal			1		Place of Dea	ath (Check only o	one)			
L.	17 Yes 2□ No	Hospital:	27	R/Outpatient	3LI DOA		☐ Nursing H	lome 5 Resi			y)	
Certification:	27. Manner of Death  1 \times Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not	00 - 51 (1)	pury 2 Pay Year) 2	28b. Time of Injury	М	Injury at Work? 1  Yes	2 🗆 No		how injury occu		il Routa Number,	
Centi	4 Homicide determined	building,	etc. (Specify)					City or To	wn, State)			
edical	(Check only one) Medical Exa	hysician: To the bes miner: On the basis and manner s	of examinatio									
completely filled in Medical Cert	29b. Signature and title of pagifier	1	AA	A	29c. Lic	ense nun	nber		29d. Date signe	ed (Month,	Day, Year)	
	30. Name and address of person who	corppleted cause of	death (Item 2	23a) (Type P		O.C.	M.E.		May 2	6, 19	99	
	Joseph	Pest	ane			Stre	et, Ba	ltimore	, Maryl	and 2	1201	
State	31. Data filed (Month) Day, Year)		trer's Signatu	re /	bout	11						

MAY 2 8 1999

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### Please Type or Print In Black Indelibie Ink. Assure All Copies Are Legible.

_	1. Decedent's Nama (First, Middle, Last)	Re 2. Date of Death	g. No.	3. Tima ol Death
Physician	DOMAN	Month MAY	Day Year 1999	
/Medical Examiner	TDA ROMAIN  4a Facility Neme (If not institution, giva street and number)  4b. City, Town, or L		4c. County of Death	
LAGITIFICI	2445 HUNT DR. BALTIMO	RE	BALTI	MORE
Funeral	5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,	Year) 9. Birth	nplece (Stete or Foreign untry) W YORK
Director	214-40-2847 85 Yrs.	SEPT 24	, 1913 NE	W YORK
D 2	Usuel Residence of Decedent  10a. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits
with the Maryland a or 28a-f show the notified at Director	10a. Stete MD BALTIMORE 10c. City, Town or Location BALTIMORE			1 Yes X No
or items 23s or 28s-f sho miner must be notified at Funeral Director	10e. Street and Number 2445 HUNT DR 21209	to	g. Citizen of What Cou USA	untry?
b E.	If Yes, Give t ☐ Yes 2 No Specify:  Year or Datas:	pecify Yes or No- Plican, etc.)	14. Race · Amer Bleck, White Specify: W	
r, the Medical Completed	15. Decedent's Education (Specify only highast grade completed)  Elemantary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king	6b. Kind of Business/I	
	17. Father's Nema (First, Middle, Last)  18. Mother's Nam	ne (First, Middle, M	EDUCATIO	PIN
ic ever o Be		o trast, middle, M	UNKNOWN	3.00
T mate	19a. Informent's Neme/Reletionship (Type, Print)  19b. Mailing Address (Street and Number or Ru	ral Route Number.		
27 is me r traums	MRS. GILDA GREENBERG (DAU.) 204 BERRY VINE DR.			21117
nt: If item ry or othe	20a. Method of Disposition  t Burial 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, cremetory or other place)  SHOMREI MISHMERES SCHARES		Oc. Location - City or T	Fown, State
Importa any inju	21. Signature of Enteral Strock Levinson & BE SOL LEVINSON & BE 8900 REISTERSTOWN B	ROS., INC		
	23a. Pert1. Enter the disease, dr complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or the first later. List only one cause on each line.			Approximete Intervel Between
ysician Medical taminer	Immediate Cause (Finel disasse or condition resulting in deeth)  a. Metastutic Lung Cancinor  Due to (or es a consequence of)			Onset and Deeth Two menths
attending physician and for use as the bunk-transit clar/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.			
d by the attending stached for use.	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did tol	pecco uee contribute	to the cause of death?
Physic Physic		10/10	e 2 No 3 Pr	obably 4 Unknown
has been signer ge 2 should be d mpleted by		24a. Wes ar perform	ned?	Were eutopsy lindings available prior to completion of cause of death?
	25. Wes case refarred to medical 26. Place of Dee	1 Ye		Yas 2 No
	examinar? Hospital:	ome 5 M Beside	nce 6 Other (Spec	oihu)
death. ctor: After this y the funeral of floation: T	27. Manner of Death  1	28d. Describe ho	w injury occurred	
To the Funeral Direction of the Funeral Direct	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, death occur and menner steled.	, and due to the ca rred at the time, da	use(s) and menner as te end placa, and dua	stated. to the ceuse(s)
To the comp	29b. Signature and title of certifier 29c. License number	29	d. Date signed (Month	h, Day, Year)
	Marshall a Vivine D17873		May 25,	1999
	Marshull a June D17873  30. Nama and eddress of person who completed cause of death (Hern 23a) (Type, Print)  Mhashull A. Lestive 1838 Greene Thee Rd. Suite  31. Dete filed (Month, Day, Year)  MAY 2 8 1999  Serve B. Sparks	120 Ba	Himore,	MD 21208
State Registrar	MAY 2 8 1999 Server Signature Sports			



### Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Tima of Death RAICHLEN MAY 24 1999 5 PM 4e Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death 6107 STEWART AVE. BALTIMORE N/A If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1□ M 2□ F Yrs. 219-44-8268 SEPT 22,1907 MARYLAND Usuel Residence of Decedent 10a. Steta MD 10c. City, Town or Location 10b. County 10d. Inside City Limits BALTIMORE BALTIMIORE 1 Yes X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6107 STEWART AVE. 21215 USA 12. Was Decedent Evar in U,S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Yaar or Datas; 14. Race - American Indian, Bleck, Whita, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Stetus 1 Never Married 2 Merried SpecWHITE 1 Yes 2 No Specify: **♦** Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) SAMUEL FRIBUSH BERTHA **JACOBSON** 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 1125 NANTUCKET, MA 02554 MR. SONNY RAICHLEN (SON) 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stata Date 1 X Burial 2 ☐ Cremation 3 ☐ Removel from Stete 5-27-99 4 ☐ Donetion /5 ☐ Other (Specify) BALTIMORE, MD BALTIMORE HEBREW 21. Signature of Fu 22. Name end Address of Facility SOL LEVINSON & BROS., INC. Approximete Interval Between Onset and Death REISTERSTOWN RD. PIKESVILLE, MD 23a, Part1. Ent of the disease, or complications that caused the death. Do not shock, or more feiture. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Disease Ma Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy parformed? 1□ Yes 2□N 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only gee) Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Tima of 28d. Describe how injury occurred

**Physician** /Medical Examiner sician and buriel-transit

attending

signed by the a

certificate

funeral c

filled in by

edicai

To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifical

certificate be exec physician a

Box 68760,

Records. P.O.

Division of Vital

**Physician** 

/Medical

**Examiner** 

Director

Funerai

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Completed

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**Funeral** 

Director

tem 27 is marked other than "natural", or frama 23a or 28a-f ahow other traumatic event, the Madical Examinar must be notified at

e filed within 72 hours after il Hygiene. other then "natural", or its

permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If item 27 ie marked other any injury or other traumatic avantal.

Baltimore, Maryland 21215-0020

with the Maryland

Examiner Physician/Medical þ Completed Be 10 Certification:

Part II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 1 Yes 2 No

28a. Dete of Injury (Month, Day Year) 27. Manger of Death 28c. Injury at Work? 1 Netural 5 Pending 1 Yes 2 No investigation

2 Accident

6 Could not be determined 281. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29a. Certifier (Check only one)

29d. Date signed (Month, Dev Year) 29b. Signatura an

nd cause of death (from 23a) (Type, Print)

State Registrar

**DHMH 16 Rev 6/95** 

31. Dete filed (Month, Day, Year) 32. Registrar's Signature MAY 28

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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death 2. Date of Death Month Laura Victoria Saxon May 26, 1999 6:30 pm 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) 700 West Bel Air Ave. "Apt 224" Aberdeen Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Min 1 □ M 2 € F 87 179 12 6768 Yrs. Maryland Jan. 1, 1912 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 XNo Maryland Harford Aberdeen 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 700 West Bel Air Ave. "Apt 224" 21001 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 ☒ No Specify: 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Production Worker Aerospace 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Louis Eyre Ellen Simms 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) William Saxon Jr. (Nephew) 4037 Madonna Rd. Jarrettsville, Md. 21084 20a. Method of Disposition 20b. Placa of Disposition (Neme of cametery, cremetory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gardens 5/29/1999 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was en eutopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 3□ DOA 1 Inpatient 2 ER/Outpatient

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

1 ☐ Yes 2 No

5 Pending investigation

6 Could not be determined

Dete of Injury (Month, Dey Year)

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28c. Injury at Work? 1 Tyes 2 No 28d. Describe how Injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only

27. Manner of Death

1 Natural

2 Accident

4 Homicide

3 Sulcide

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as steted. 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certified

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Dey, Yeer)

32. Registra Signature

State Registrar

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

Director

Funeral

by

Completed

r than "natural", or Nems 23s or 28s-f show the Medical Examiner must be normed at

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death

filed within 72 hours after Hygiene.

permit. Pages 1 end 2 should be filled wi Department of Health and Mental Hygien Important: If itam 27 Is marked other tha any Injury or other traumatic event, Train once.

**Physician** /Medical

Examiner

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herel Director: After this
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within 24 hours e To the Funeral C completely filled

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The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records,

or Attending Physician:

Physician/Medical Examiner

by

Completed

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Certification:

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Daath Month Dev Yeer **Physician** 5:30 PM 1999 FLORENCE S. FOARD MA 25 SOLLAWAY /Medical 4c. County of Death 4b. City, Town, or Location of Deeth 4a Fecility Name (If not Institution, giva street and number, Examiner PAIZE VILLE
II Under 24 Hrs. 8. Dat SOIT WENDALL DAOSI BALTIMORE If Undar 1 Yaar Birthplaca (State or Foreign Country) 6 Sax 7. Aga (In yrs. last birthday) 5. Social Sacurity Number **Funeral** Min. 1 M 2 F Months Days Hours Yrs. **Director** 213-03-9465 JUNE 29, 1914 MD Usuel Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits e filed within 72 hours after death with the Marylan at Hygiene.

It Hygiene.

It Hydier than "natural", or flems 23s or 28s-f show vert, the Medical Examine must be notified at vert, the Medical Examine must be notified at 1 ☐ Yas 2 ☐ No Director MD PARKVILLE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? WENDALL PARKVILLE U.S.A Funeral 8617 ROAD 12. Wes Decedant Evar in U,S. Armed Forcas?

1 Yes, 2 No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Rece - Amarican Indian, 11. Marital Status Bleck, White, etc. 1 Never Merried 2 Merried 1 Yes 2 No Specify: Maryland 21215-0020 by 3 Widowed 4 □ Divorced WHITE Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elementery/Secondery (0-12) College (1-4or 5+) + 4 ELEMENTARY SCHOOL TEACHER EDUCATION 12 traumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be permit. Pagas 1 and 2 should be f Departmant of Health and Mental I Important: If from 27 Is marked of FOARD FRANK B. HATTIE V... SMITH-19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) 407 ORCHARD LA MEZHANICS BURG PA 17055
see of Disposition (Name of Date 20c. Location - City or Town, State BEVERLY V. WARD , DAUGHTER other Baltimore. 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition MAY 25, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) 1999 PARKVILLE, MD PARK WOOD COMETERY 21. Signature of Puneral Service Licenses 22. Name and Address of Facility EVANS CHAPEL OF MEMORIES 8800 HARFOED ED. PARKVILLE, MD. 21234 23a. Pent (Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heert failure. List only one cause on each line. Approximete Intervel Between Onsat and Death **Physician** · acute myocardial /Medical Immediate Cause (Final disaase or condition rasulting in daath) Examiner Examiner sician and burial-transit cartificata be axecuted Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequenca of): Division of Vital Records, P.O. Box 68760, attanding physician for usa as the buria Physiclan/Medical Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes en autopsy Completed 1 Yes 2 No 1 Yes 2 No 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) To 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA this 28a. Dete of Injury (Month, Day Year) funaral 27. Menner of Death 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of Aftar Certification: 1 Naturel 2 ☐ Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Pleca of Injury - At homa, farm, straat, factory, office building, etc. (Specify) filled in by 4 - Homicide 24 hours Hospital 12 Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, date and placa, end due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end manner stated. 29a. Certifier Medical (Check only one) To the P 29d. Dete signed (Month, Day, Year) 29b. Signature end title of certifiss 29c. License number MAY 27 1999 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

@HH

DHMH 16 Rev 6/95

State Registrar MICHAEL K

31. Date filed (Month, Day, Year)

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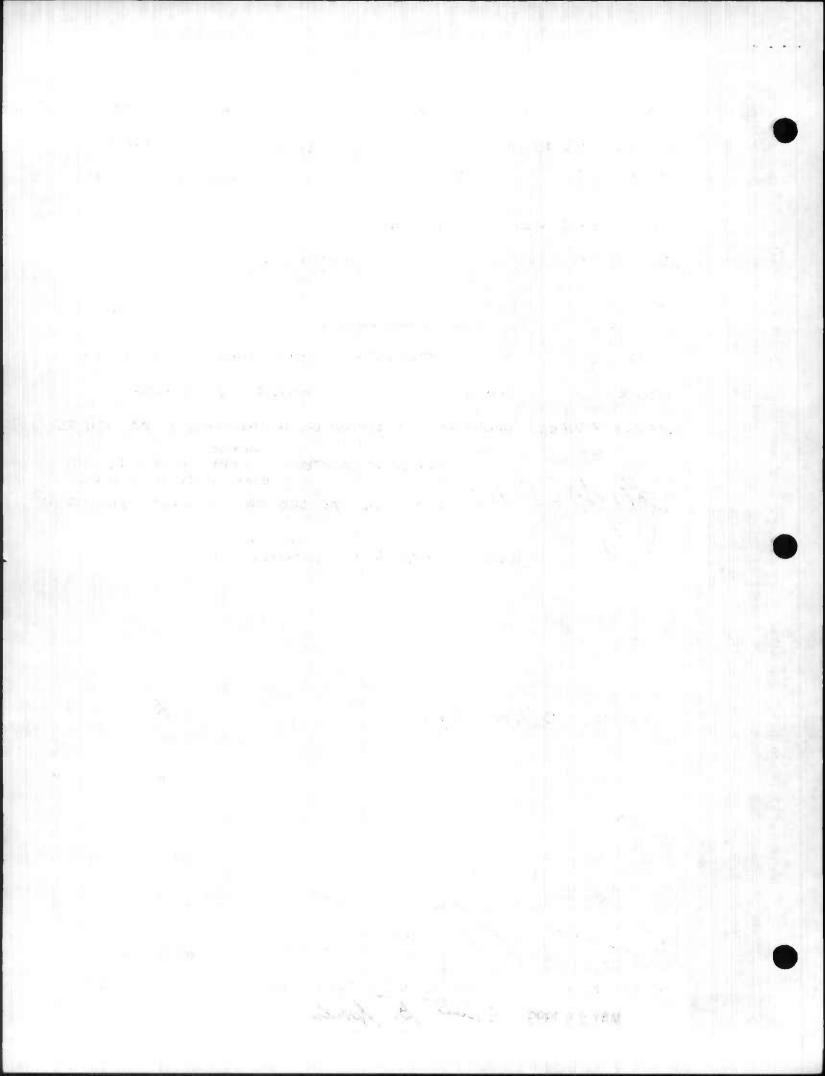
MAY 28 1999

2314

32. Registrar's Signature

GAOS APPORT

PARKVILLE MD. 21234



#### Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year PAUL THOMAS STARTI 3 05 12:00 am 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 201 Brookletts Ave. Talbot If Under 1 Year If Under 24 Hrs. Hours Min. 8. Dete of Birth (Month, Day, Year) 63-28-23 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Deys 215 20165 76 Maryland Usual Residence of Decede 10a. State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits TALBOT MD 1 ☐ Yes 2 No EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 BROOKUTTS AVENUE V.2. A. 21601 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 □ No If Yes, Give Year or Detes: 3/46 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. 11. Marital Status Bleck, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 3/46 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Postal Rural mail carrier 11 0 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Edward Kenly Startt Nora Genevieve Stewart 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Nina Marie Startt/wife 201 Brookletts AVe., EAston, MD 21601 20a. Method of Disposition 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 X Donation 5 ☐ Other (Specify) 21. Signature of Furnisal Service License 22. Name end Address of Facility Ronald Wade Director State Anatomy Board, 655 W. Baltimore Street ulls Baltimore, MD 21201 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart feiture. List only one cause on each line. Intervel Between Onset and Deeth Immediate Cause (Finat disease or condition resulting in death) cardiotes or rator 6 MINUTES Due to (or as a consequence of) men the stanc honsmal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence ot): Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown COPD-Emphysema 24b. Were autopsy tindings aveilable prior to completion of cause of death? 24a. Wes an eutopsy performed? 1 ☐ Yes 2 ☐ No 25. Wes case referred to medicat examiner? 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) 28d. Describe how injury occurred

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

Director

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Completed

Be

**Funeral** 

Director

r than "naturel", or frame 23a or 28a-f ahow the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if Item 27 le marked other than "naturel", or fren eny Injury or other traumatic avant, tra Heddell Examples.

Baitimore, Maryland 21215-0020

Box 68760

Records, P.O.

Division of Vital

Hospital

To the Hosp within 24 hos To the Fune completely fi

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Ne Funeral Director: After pletaly filled in by the fur

Physician/Medical þ Completed Be Certification: To 27. Manner of Death

edical

Examiner

2 Accident

3 ☐ Suicide

29e. Certifier

4 Homicide

(Check only one)

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

28b. Time of

1 Yes 2 No

281. Location (Street end Number or Rural Route Number, City or Town, Stete)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signeture and title of certifier Salu

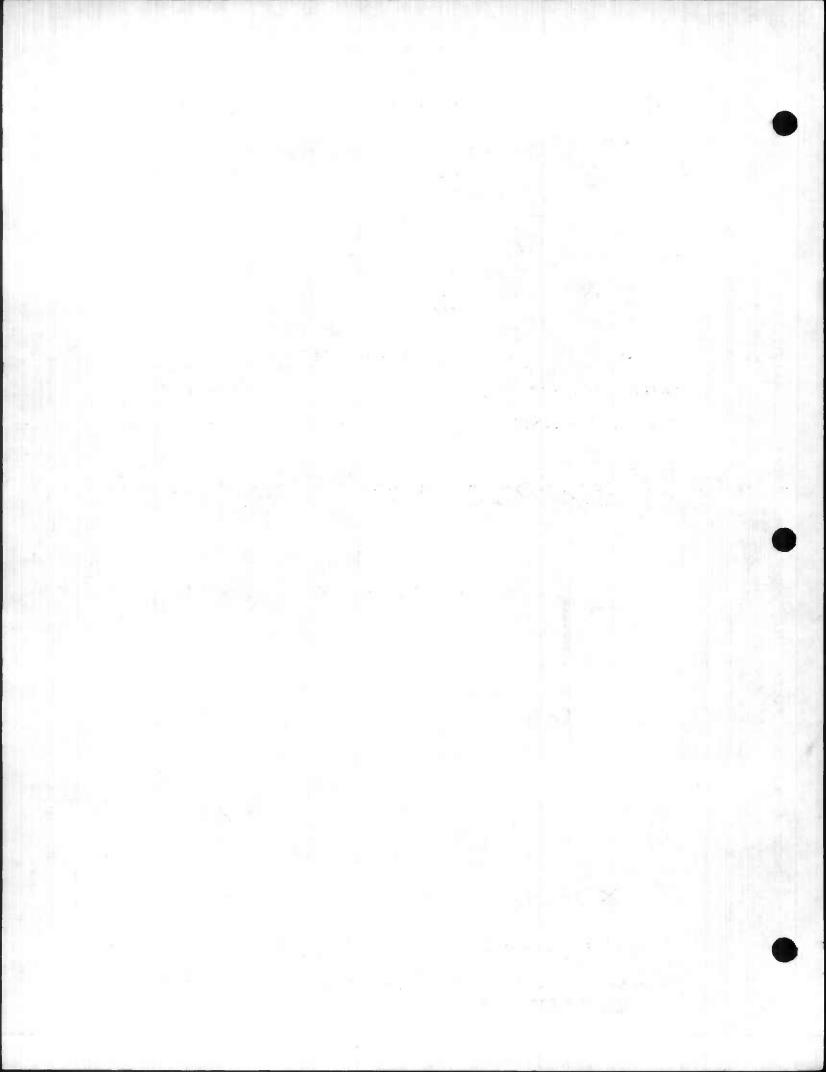
29c. License number 13664 29d. Dete signed (Month, Dey, Year) 5-20-99

address of person who completed cause of death (ttem 23a) (Type, Print)

ASSOLATORM 32. Registrar's Signeture

IDDIEWIND AVE EASTON MD 21601 509

State Registrar



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

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l'ec	10e. Street end						10f. Zip	p Code				10g. Citizen	of Whet Co	ountry?	
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State Registrar

29e. Cartifier (Check only one)

111 Penn Street, Baltimore, Maryland 21201 MAY 27 1999

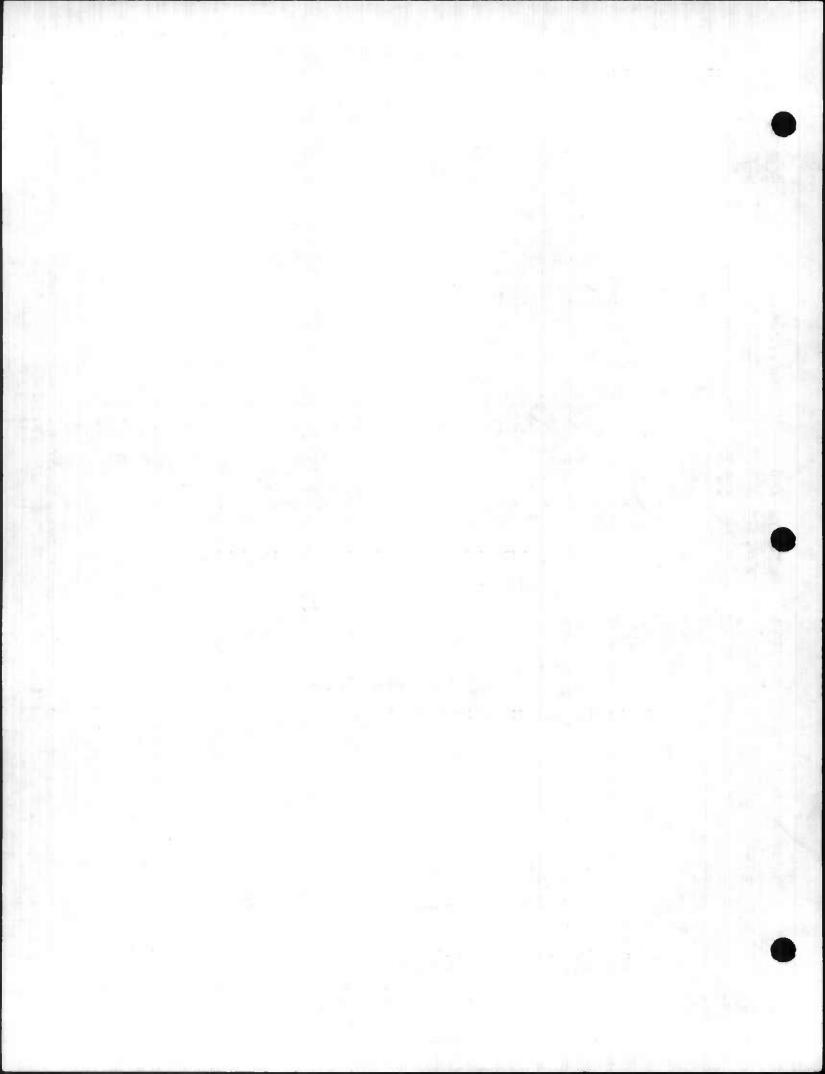
1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

XXMedical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29c. License number

O.C.M.E.

29d. Dete signed (Month, Day, Year)

APRIL 21,1999



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Wealth and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Month Year Margaret W. Sparrow 4c. County of Death MAY 1999 1:45 PM 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Saint Joseph Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1□ M 2월 F Yrs. 71 229-22-5140 1927 North Carolina August 11, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 1 No MD. Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 246 Linden Ave. 21286 USA 12. Was Decedent Ever in U,S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Bleck, Whita, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Merried 1 Yes 2 No Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Communications Stella Maris 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Bertha Woolard Ottis Woolard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William V. Sparrow (husband) 246 Linden Ave. Towson, MD. 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method ot Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 DOther (SpecifyEntombment Dulaney Valley Mem. Grdn 5/29/99 Timonium, MD. 21 Signature of Funeral Service Ligange Dennis C. Carroll 22 Name and Address of FacilitRuck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 21204 23a Partitioner the disease, or complications that ceused the death. Do not enter the mode of dying, such es cerdiec or respiretory errest, not, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Cause (Final NON-HODGKIN LYMPHOMA disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 NO 1 Yes 200 No 26. Place of Death (Check only one)

**Physician** /Medical Examine

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**Physician** 

/Medical

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Director

Funeral

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Completed

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**Funeral** 

Director

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with the Manyland

filed within 72 hours after

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Baltimore, Maryland 21215-0020

Box 68760

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Division of Vital Records,

Examiner Physician/Medical 980 þ Completed Be

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Certification:

physician and s the burial-transit ed by the detached signed by t has this i or Attendin after death. Director: Att d in by the fu

PANCYTOPENIA RENAL FAILURE 25. Was case referred to medical

examiner?	Hospital: Unpatient 2 ER/Outpatie	nt 3 DOA Other: 4 Nursing I	Homa 5 ☐ Residence 6 ☐ Other (Specify)
27. Magner of Death  1 SNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injury	f 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how injury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, ferm, s building, etc. (Specify)	eet, factory, office	28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29e. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. nination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D 30263

29c. License number

29b. Signeture and title of certifier

29d. Date signed (Month, Day, Year) 05-76-99

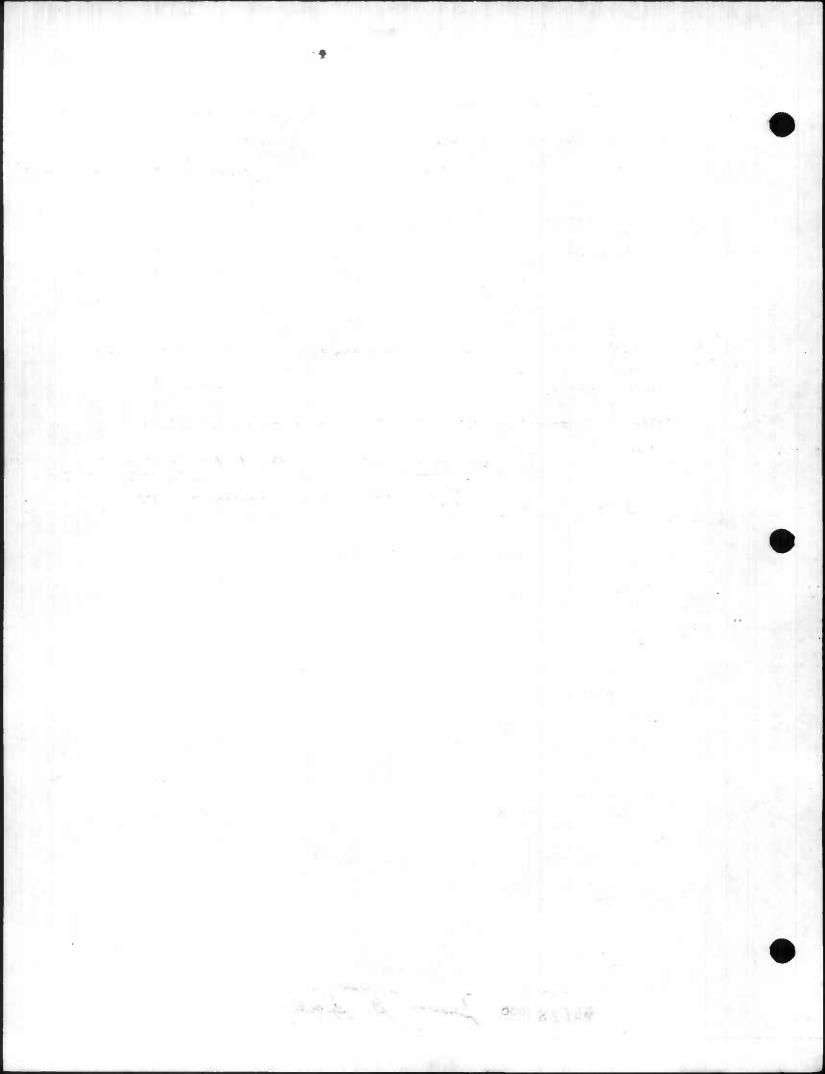
30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

7601 DSI 32. Registrans Signature FRANCIS KHOO, M. Dry OSLER\_DR-THEON, MARYLAND 21204 31. Date filed (Month, Day, Year)

State Registrar

**DHMH 16 Rav 6/95** 

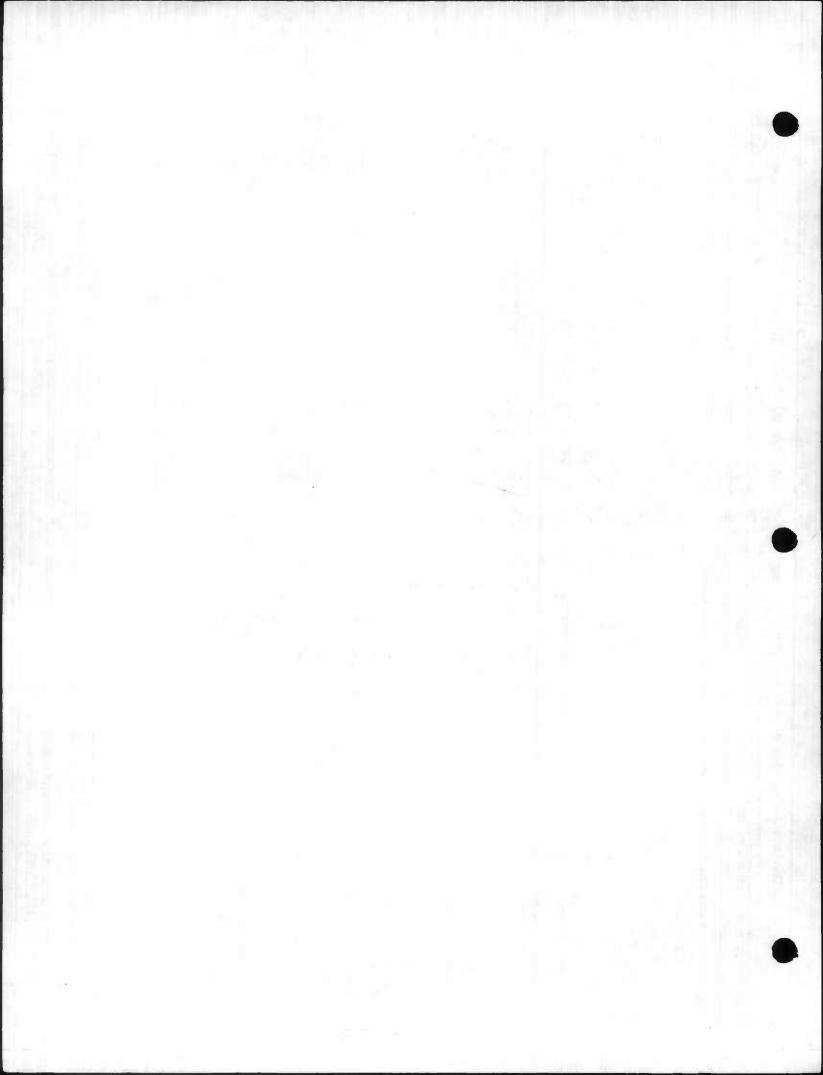
To the Hospital o within 24 hours af To the Funeral Di completely filled in



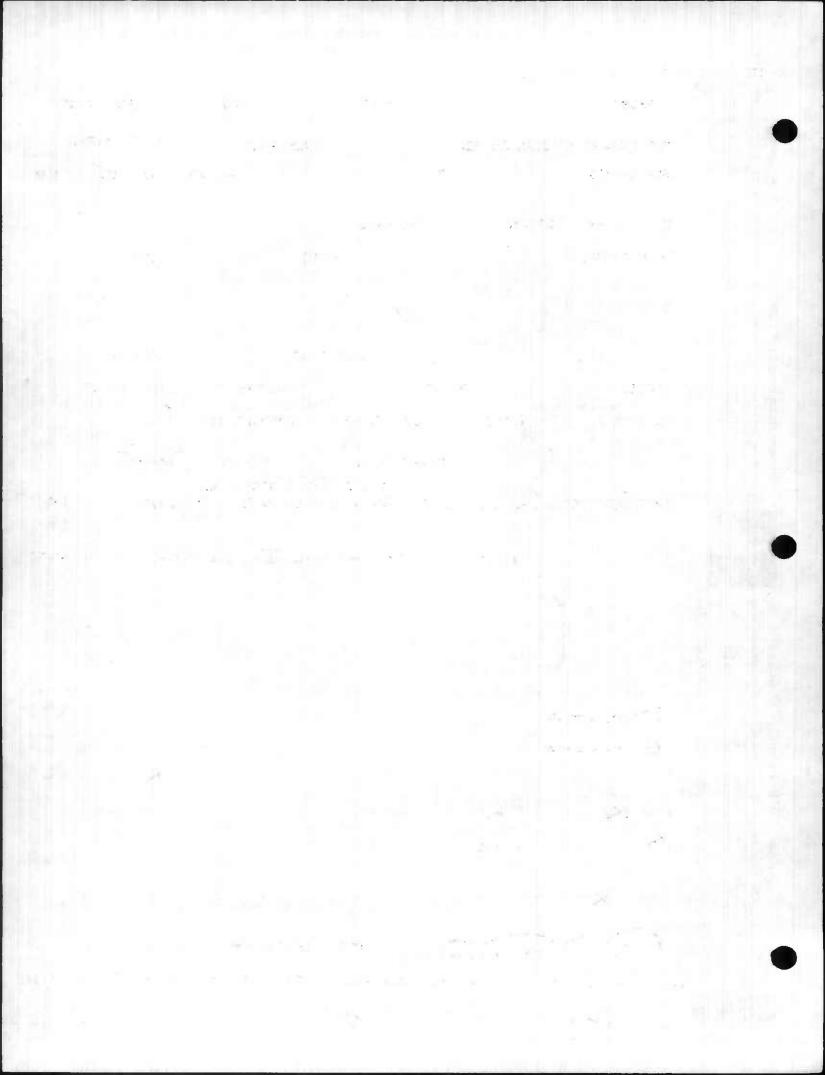
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Dhucisian	The state of the s	ame (First, Middle	, Last)		Cei	tificate			2. Data of Dea Month	eg. No.	3. Tima of Dec				
Physician /Medical	MOISE	Υ				SLUT			May 24,	1999	5:58 p.:				
xaminer		a (If not institution Hospital	7					b.City,Town,orLo Baltimore	cation of Death	4c. County					
eral ctor	5. Social Sacurity 216-53-		6. Sax 1 M 2 □ F	7. Aga (In yrs. 63	last birthday) Yrs.	If Under 1 Y Months D	ear nys	If Under 24 Hrs. Hours Min.	8. Data of Birth (Month, Day) AUG 13	Year) 1935	9. Birthplace (State or Fo				
	Usual Rasidence	of Dacedant 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City L				
uneral Director	MD	N/A			BALI	IMORE					1 Yas 2				
I Director	10e. Street and I	Number VEN MILE	LANE			10f. Zip Co	de	21208	1	10g. Citizen of What Country UKRAIN					
by Funeral	0.25	s arried 2 Marri	Armed	: 2 □No Siva		Was Decedent f Yes, specify		spanic Origin? (Span, Mexican, Puarto	ecify Yas or No- Rican, atc.)		ce - American Indian, ck, Whita, atc. WHITE				
nem 27 is merced other than "saturn other traumatic event, the Medical is To Be Completed		15. Decedant pecify only highes econdary (0-12)	grade completed	f) (1-4or 5+)	16a. Deced (Giva lifa. L	dent's Usual O kind of work d DO NOT use n ELECTR	ona d etired)	luring most of work	ing		usiness/Industry				
	17. Fathar's Nan	na (First, Middla, L	ast)			ELECIK	101	18. Mother's Name	a (First, Middle, I		TRACTING				
					UNKNO	NWN					UNKNOWN				
		19a. Informant's Name/Ralationship (Type, Print) MRS. LARISA SLUTSKAYA (WIFE)  19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State 3703 SEVEN MILE LANE BALTO., MD 212									. Stata, Zip Code) 21208				
	20a. Method of Disposition  1 Burial 2 Cramation 3 Removal from Stata 4 Donation 5 Other (Specify)  20b. Place of Disposition (Nama of cematary, crematory or other place)  BALTIMORE HEBREW  20c. Location - City or Tot cematary, crematory or other place)  BALTIMORE														
	21. Signature of	Tytheral Service L	Johnson H		22	SOL LE 8900 R	VIR EIS	STERSTOWN	OS., INC		LE, MD 21208				
Examiner	Immediata Caus diseasa or cond resulting in daat	ition h)	a	diogeni	or as a consequence Shock	ζ					Onset and Deal				
	Sequentially list conditions, if any, laading to immadiate causa. Entar Underlying Cause (Disease or injury that initiated events resulting in daath) Last  Dua to (or as a consequence of):  Resection of Ascending Aortic Aneurysm  c.  Dua to (or as a consequence of):														
an/Me	14.111 14.00 (14.00)		d. Tri	ple Coro	onary A	Artery	Вур	pass							
detached for use as the but th									23b. Did tobacco use contributs to the cause of						
									24a. Was a perfor	n autopsy med?	24b. Wera autopsy findi available prior to completion of caus of death?				
by									1 🗆 Y	as 2 No	1 Yas 2 No				
by								26. Place of Deat	h (Check only or						
Be Completed by	examinar?	farred to madical	Hospital	,			000	Pospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 8							
In director, page 2 should be d To Be Completed by	examinar?	□ No	19					4 LI Nursing Ho							
To Be Completed by	examinar? 175 Yes 2 27. Mannar of De 1 Watural 2 Accident 3 Suicide	No eath 5 Pending invastig 6 Could n	28a. Dat (Mo	a of Injury onth, Day Year)	28b. Tima of Injury	28c.	Injury Work	y at (? Yas 2□No	28d. Describe h	ow injury occur	rred				
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Il director, page 2 should be d To Be Completed by	examinar?  15 Yes 2  27. Mannar of De  1 Xeatural 2 Accidant 3 Suicide 4 Homicid	Death  5 Pending invastig  6 Could n detarmi	28a. Dat (Mc ation of be ned 28e. Pla- buil	a of Injury nith, Day Year)  ce of Injury - At h ding, atc. (Specif na best of my kno basis of axamina	28b. Tima of Injury  oma, tarm, str	eet, factory, of	Injury Work 1 1 1	r at (?? Yas 2 □ No	28d. Describe h 28f. Location (S City or Tow and dua to the c ed at tha tima, d	treet and Numi n, State) ause(s) and m lata and place,	ber or Rural Route Number, annar as stated, and dua to tha cause(s)				

ORIGINAL



EM: #20C F	ER F.H. G771 5-28 ,199			artment of rtificate of			Reg. No.	17	146
Physician /Medical	Decedent's Name (First, Middle, Li HELEN	ist)	ST	ERN		2. Dete of Dee Month MAY		Year	3. Time of Death 8:45PM
Examiner	4a Facility Name (If not Institution, git ANNE ARUNDEL MED			4b. City, Town, or ANNAPOI		4c. County of Death  ANNE ARUNDEL		DEL	
Funeral Director			yrs. lest birthdey) 83 Yrs.	If Under 1 Yes Months Day		(Month, De	y, Year) 3, 1916		ce (State or Foreign v) NECTICUT
28a-f ahow notified at rector	Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or Lo	cation				10d	I. Inside City Limita  ¶ Yes 2 □ No
be notified Director	MD ANNE AR  10e. Street and Number	UNDEL	ANNAP	10f. Zip Code			10g. Citizen of V	Vhat Country	
iber must Funeral	909 COACHWAY  11. Maritel Stetus  1 Never Merried 2 Married	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2♥ No If Yes, Give				nlc Origin? (Specify Yes or No- lexican, Puerto Rican, etc.)  14. Race - Am Black, Wh			
edcel	3 Widowed 4 □ Divorced  15. Decedent's E (Specify only highest gr  Elementary/Secondary (0-12)	Year or Dates:  ducation ede completed)  College (1-4or 5+)	16e. Dece (Give life.	dent's Usual Occ kind of work don DO NOT use reti	upation e during most of wo red)	16b. Kind of Business/Industry			
Be	12 17. Father's Name (First, Middle, Las		DLDEN	CORSE		me (First, Middle,	Maiden Sumem	CLOTHING TO Sumeme) SILVERSTONE	
To	19a. Informant's Name/Relationship		19b. Mailir	ng Address (Stre	et end Number or Ri ANNAPOI	ural Route Numbe			
To Be Comp	20a. Method of Disposition  1 Burial 2 Cremation 34 Donation 5 Other (Special Control of	Removel from State	Ob. Place of Disponsion CHAPEL	metory or other p	/eca)	Dete /25.99	20c. Location - LARGO,		
ODCO.	21. Signature of Funeral Service Lica	nsee	22 S	Name and Add		OS., INC.	IKESVILL		21208
Medical Certification: To Be Compieted by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last	bDue	to (or as a consect to (or a consect to (or a))).	quence of):					
be detached for usa as by Physician/Me	Pert II. Other significant conditions		ot resulting in the u	nderlying cause	given in Part I.		tobacco uae cor Yss 2□ No		he cause of death?
Completed by Physician/Me	DEMENTIA GLASCOMA	3				24a. Was perfo	an autopsy	availe	a autopsy findings able prior to pletion of cause
Сотр						10	Yes 2000		Yes 2□ No
the funeral director, page catlon: To Be Com	25. Was case referred to medical examiner of Deeth    Was 2 No  27. Menner of Deeth   Watural   5   Pending   Investigation	10/14	opatient 2 ER/Outpatient 3 DOA Other			eth (Check only of Home 5 Reale 28d. Describe I			
completely filled in by the funera Medical Certification:	3 Suicide 6 Could not 1 determined	28e. Place of fnjury - building, etc. (S	pecify)			City or Tox			
mpletaly Medica	(Check only 2 Nedical Exa	miner: On the besis of exa and manner stated.	mination and/or in	vestigetion, in my	opinion, death occi	urred at the time,	date and place,	and due to th	he cause(s)
200	29b. Squared and title of certifier  30. Name and address of person who	DS MITCI-	(Item 23a) (Type	mo Print)	- D350	37	29d. Date signed 5-24	1-99	1
State Registrar	DOUGEAS 5 MIT 31. Date filed (Month, Day, Year) MAY 28	32. Registrar's	Signature	4. Sou		CENTVZ	,ann,	APOL	SMO



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death **Physician** .M. - 30 BERTHA SULLIVAN MAY 26, 1999 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner 218 N. PORT ST. BALTIMORE NA If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) 5. Social Security Number Birthplace (Stete or Foreign Country) 6. Sex 7. Age (In yrs. last birthdey) **Funeral** 1□ M 2 F Months 219-22-6007 72 Yrs. APRIL 24, 1927 OHIO Director Usual Rasidence of Decedent permit. Peges 1 and 2 should be filed within 72 hours effer death with the Meryland Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinal must be notified. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD NA BALTIMORE 1 Yas 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 218 N. PORT ST. U.S.A. 21224 Funerai 12. Was Decedant Evar In U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, Whita, etc. 1 Yes 2 No If Yas, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOME HOMEMAKER 12 TH NA 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) HENRY (UNKNOWN DILLOW SARAH E. 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MARY E. MARTIN - DAUGHTER 2416 E. FAYETTE ST. - BALTO., MD. 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other pleca) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 5/28/99 BALTO, MD. GARDENS OF FAITH CEM. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HARTLEY MILLER FUNEAAL HOME, CHTD. 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) FAILURE RESPIRATORY Examiner Due to (or as a consequence of): Examine COPD physiclen and the buriel-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Dua to (or as a consequance of) 88 esn signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other elgnificant conditions contributing to death but not resulting In the underlying cause given In Part I. 3 Probably 4 Unknown 1 Yes 2 No ð 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed certificate hes b irector, page 2 s 1 Yes 2 No 1 ☐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending death. 1 Yes 2 No Investigation 2 Accident efter deatl Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 4 Homicide filled in hours 24 hours 29a. Certifier 🖼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated edicai To the Hosp within 24 ho To the Fune completely f (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and mannar stated.

Registrar

31. Date filed (Month, Dey, Yeer) MAY 28 1999

GILBERT

29b. Signature and title of certifier

DESMANGLES MA 32 Registrar's Signature

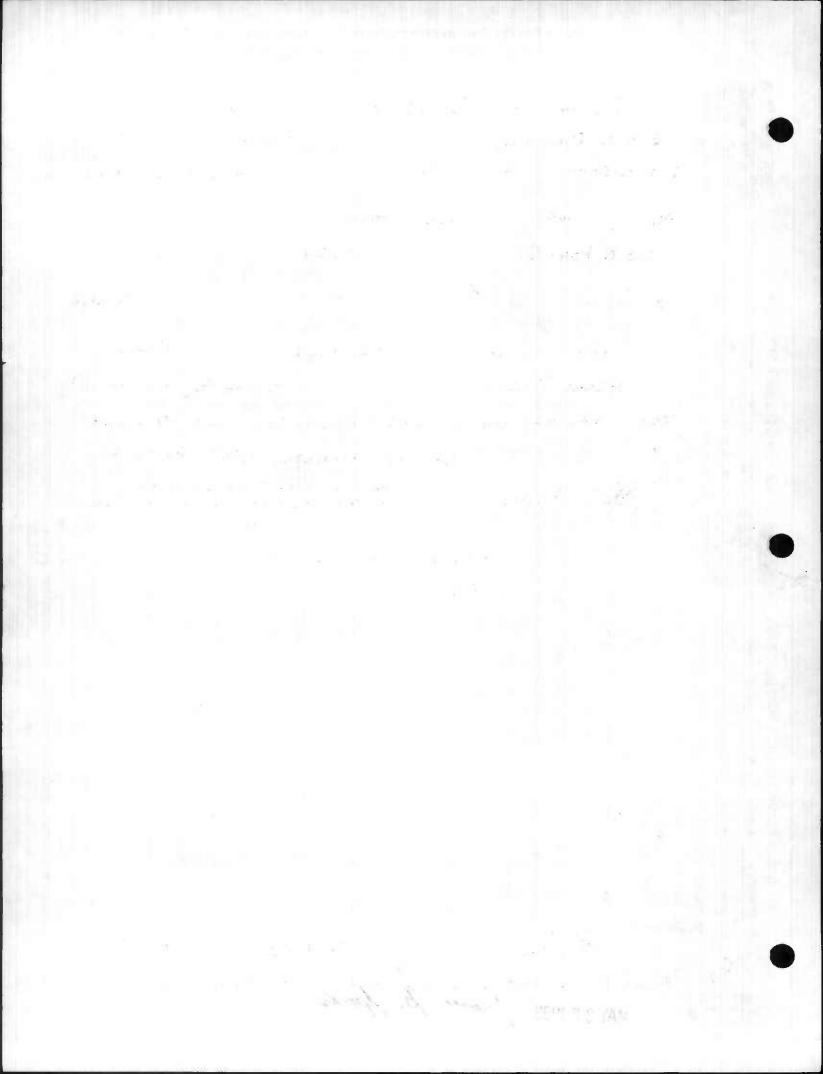
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D44100

29c. Licansa number

LOON. BROADWAY, BALTO MD 21231

29d. Date signed (Month, Day, Yaer)



### Please Type or Print in Black indelible lnk. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death THOROTTOOK Day DOROTHEA Month 11:50 Pu 1999 05 26 4a Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Hotlite BOOK SECOURS Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Apr 27, 1913 5. Sociel Security Number 6 Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 1□ M 2□xF Months 86 220-14-0611 Maryland Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10b County MD N/A 1 XYes 2 No Baltimore. 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 142 North Denison Street 21229 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 14. Race - American Indien, Black, White, etc. 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 TNo Specify: Specify: Black 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 12th College (1-4or 5+) Housewife Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) William Williams Maggie Brown 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Audrey Brown (Daughter) 142 N. Denison Street Baltimore, Maryland 21229 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Date Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Maryland Nat'l Mem Pk 6/02/99 Laurel, Maryland 22. Name and Address of Facility Caple Funeral Service 21. Signature of Funeral Septor Decrisee 5502 Winner Avenue Baltimore, Maryland 21215 Fig. 1. Enter the disease for complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death SEPSIS. Immediate Cause (Final Due to (or as a consequence of): disease or condition resulting in death) PER: PHERME UNICULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Cooklessive HBART failure 1 Yee 2 No 3 Probably 4 Unknown RESPIRATORY Failur 24b. Wera autopsy findings eveilable prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 PNo 27. Manner of Death 1 Dinatural 28b. Time of 28d. Describe how Injury occurred

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23a or 26a-f show the Medical Examiner must be notified at

Hygiene.

Peges 1 and 2 should be filed v nent of Health end Mentel Hygie nt: if item 27 is marked other t

6

permit. Pege Department of Important: If any Injury or

Director

Funeral

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Completed

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Maryland 21215-0020

altimore,

P.O. Box 68760.

Records,

Division of Vital

physician and the burief-transit 8 USB page 2

director.

Examiner Physician/Medicai Be To Certification:

PV Completed

ed by the e signed t certificate Hospital or Attending Physician: this After efter deeth. 24 hours

To the Hospi hithin 24 hou To the Funer completely fil edicai

2 Accident 3 Suicide

4 Homicide

29a. Certifier

29b. Signature end title of certifier

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. fnjury at Work? 1 ☐ Yes 2 ☐ No

281. Location (Street end Number or Rural Route Number, City or Town, Stete)

1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, dete end piece, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number

ATTEMSionle PHYKiclas D13248 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

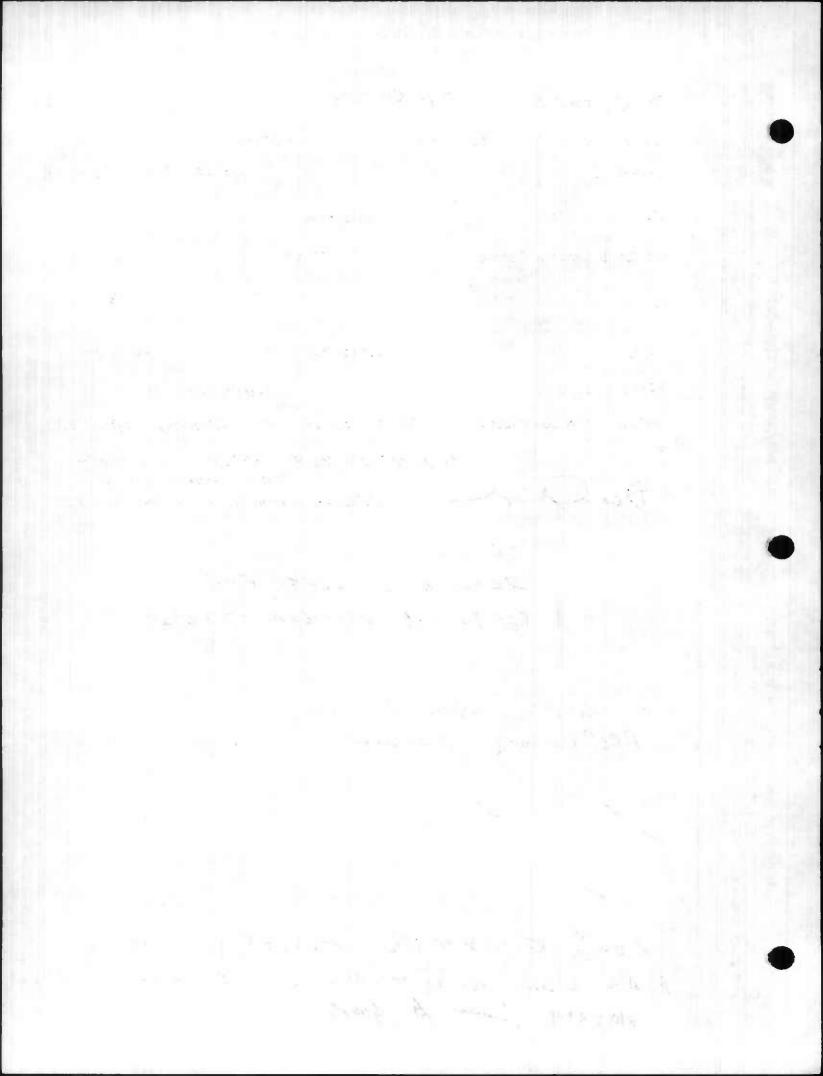
ATAIL SID HU 1510 6. mol HER Cf. NALTIMORE WILDID

State Registrar

MAY 2 8 1999

31. Date filed (Month, Dev. Yeer)





Please Type or Print In Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ITEM: 16B PER F.H. G771 5-28-99 WR. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day 1h Month Year **Physician** Willie may 1999 Tillery 26 /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Union Memorial Hosp. [7. Age (In yrs. last birthday) Baltimore # Under 1 Year Birthplaca (State or Foreign Country) 5. Social Security Number 8. Dale of Birth (Month, Day, Year) 6. Sex M M 2□ F **Funeral** Months Hours Yrs Director 64 03 11 N.C. 212-32-8625 Usual Residence of Deced filed within 72 hours after deeth with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits worde r than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at XXYes 2 No Director MD NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 14. Rece - American Indian, Black, White, etc. Funeral 713 North Appleton Street 21217 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 11. Meritel Status 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 1 ☐ Yes 2 No Specify: altimore, Maryland 21215-0020 Specify: Black by 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent'a Education (Specify only highest grade completed) 16b. Kind of Business/Industry VARIOUS JOBS Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Laborer Varies Jobs 7 le marked other treumatic event, I permit. Pages 1 and 2 should be file Department of Heelth and Mentel Hy Important: If item 27 is marked oth any injury or other treumatic event Bloss. 17. Father'a Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be 2 Gladys Higgs Robert Lee Tillery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, Stete, Zip Code) Myra Ford-Daughter 3408 Wild Cherry Road, Baltimore Md 21244 20b. Pleca of Disposition (Name of cemetery, cremetery or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremetion 3 ☐ Removei from Stete 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 5/29/99 Arbutus, Md 21. Signeture of Funeral Service Licansee 22. Name and Address of Fecility Glady March F/H West W arra 4300 Wabash Ave, Baltimore Md 21215 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediete Cause (Final Pneumonia - aspiration 4 hours disease or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner Metastatic lung cance alo months end I-transit that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): physician e P.O. Box 68760. edicai Due to (or as a consequenca of) 85 attending for use as Physician/M Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? ed by the 3 Probably 4 Unknown 1 Yes 2 No Division of Vital Records, P sign De The law requires 24b. Ware eutopsy findings available prior to Completed 24a. Wes an autopsy performed? completion of cause of death? i certificate has l 2 No 1 ☐ Yes 2 ☐ No Attending Physicien: director. Be 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Naturel 5 Pending death. 1 Yes investigation 2 Accident Mospital or Attend 24 hours eftar death Funerel Director: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours e 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as stated. To the Hosp within 24 hou To the Fune completely fil Medical 29a. Certifier (Check only one) 2 Medical Examinar: On the besis of examination and/or investigation, in my opinion, death occurred at the time, dete end plece, and due to the cause(s) end menner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of selfillier 29c. License number May 26 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 3333 N. Calvert St. Baltimore, Md 21218 0

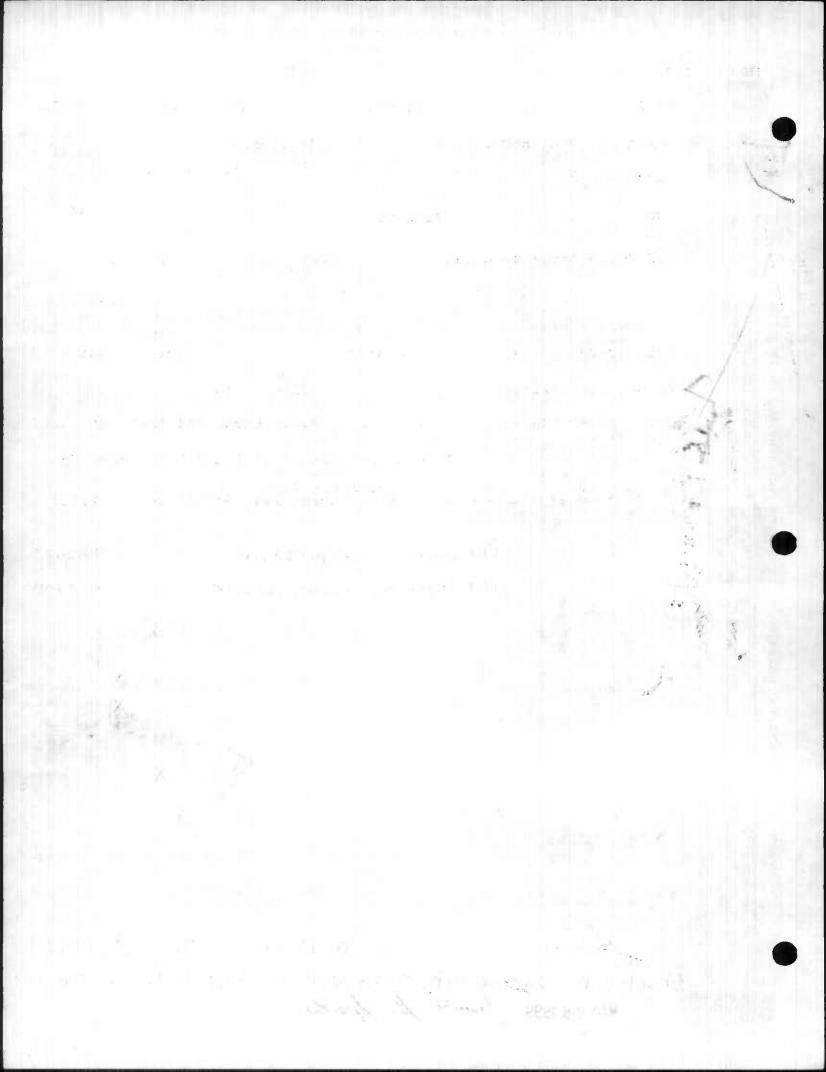
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State Registrar

31. Dete filed (Month, Day, Year) MAY 28 1999

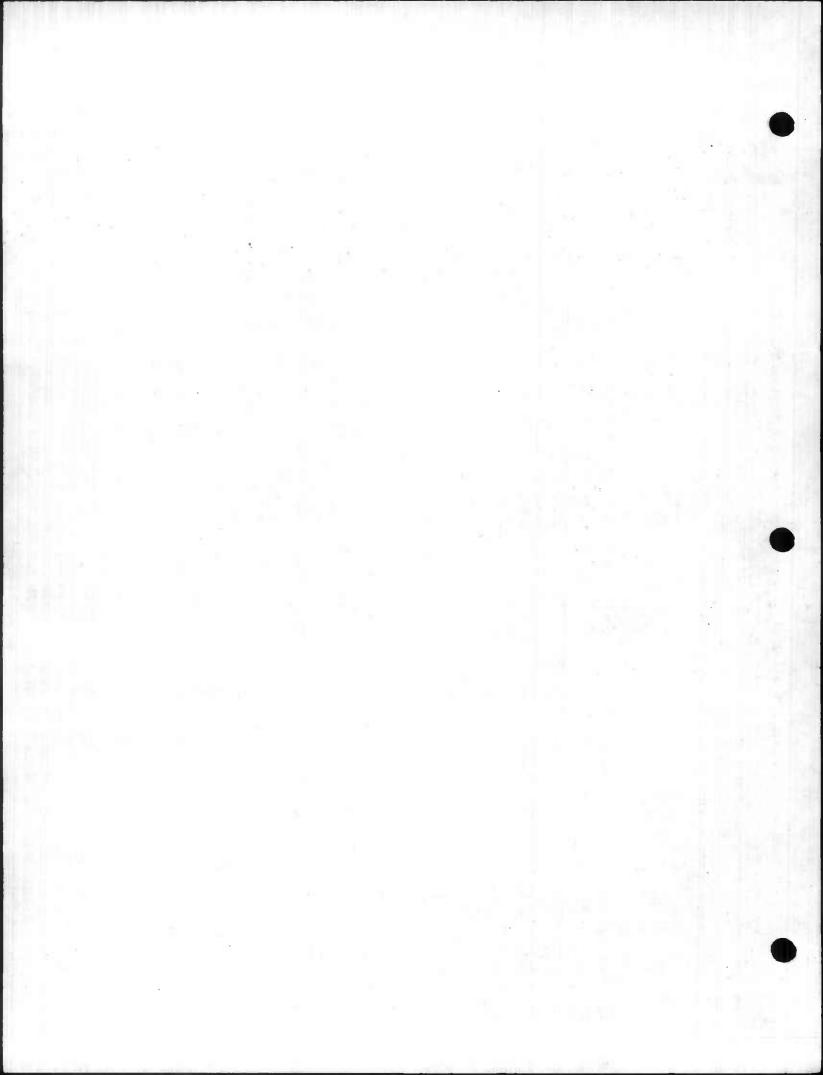
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Jalker, MD 32. Registrar's Signature



# Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Oldic of W	-	Certificate of			leg. No.	1/150		
Physician	Decedent's Name (First, Middle, L     Dorothy	est)			Truitt	2. Dete of Dea Month May 17	Day \	3. Time of Death		
/Medical Examiner	4a Facility Name (If not institution, gr	ive street and number,			4b. City, Town, or L		4c. County of	8:20 AM		
Examiner	Salisbury Center	r: Genesis	ElderCar	re s	alisbury,	MD	Wicomio	20		
Funeral	5. Social Security Number 6.	Sex 7. A	ge (In yrs. last birth		If Under 24 Hrs.	8. Date of Birth (Month, Day		9. Birthplace (State or Foreign Country)		
Director	062-26-5779 Usual Residence of Decedent	1□M 2፟MF	65 <sup>Y</sup>	rs. Morans Days	Hours Min.	Oct. 3,	1933	New York		
	10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits		
or 28a-f s be notified Director	Maryland Wicomic	0	Salisb	ury				1 ☐ Yes 2]() No		
Olre	10e. Street and Number		1	log. Citizen of Wh	at Country?					
ath w	815 D Smith Stre			2180			U.S.A.			
13-0020 172 hours after death with the Maryler 72 hours after death with the Maryler disalical Examiner must be notified at letted by Furneral Director	11. Merital Stetus  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Wes Decedent Armed Forces  1 Yes 2 1 1 Yes, Give Year or Detes:		13. Was Decedent of ≱ If Yes, specify Cub  1 ☐ Yes 2 ☒ No		pecify Yes or No- Plican, etc.)		American Indian, White, etc. white		
sales and		ducetion	16a. [	Decedent's Usual Occup	pation		16b. Kind of Busi	ness/Industry		
Maryland 21215-0020  2 should be filed within 72 hours at the and Mariat Hygiene. The rearised other than "natural", or The rearised other than "natural", or Traumatic event, the Medical Exam To Be Completed by F	(Specify only highest gi	College (1-4or	5+)	Give kind of work done life. DO NOT use retire	during most of work d)	king				
Co Martin	12 17. Father's Name (First, Middle, Las	2		Bookkeeper	18. Mother's Nam		unknown			
Be ever										
To To	William Nicholas  19e. Informant's Name/Relationship		104	Mailing Address (Street			Gorecka			
Ma d 2 s Than Traus	Jennifer Haken/d			Crest Ave.						
	20a. Method of Disposition	augnter	20b. Place of I	Disposition (Name of	1	7		ity or Town, State		
Dallimore, semit. Pages 1 at Separtment of Healmportant: if Item myortant: if Item my injury or othe Dice.	1 ☐ Burlat 2 ☐ Cremetion 3 [ 4 🖔 Donation 5 ☐ Other (Spec	ity)	cemetery	, crematory or other pla						
Demil Depart Important Imp	21. Signature of Funeral Service Lics Ronald	Sy Wade, D	irector	State Anat Baltimore	comy Board		. Baltim	ore Street		
Physician /Medical Examiner	2.3a. fast 1. Enter the disease, or consider, or heart failure. List only Immediate Cause (Final disease or condition	nplications that cause y one cause on each i	d the death. Do not not not not not not not not not no	ot enter the mode of dyi	ng, such as cerdiac	or respiratory arr		Approximate Intervel Between Onset and Death		
ě	resulting in death)		Due to (or as a co	onsequence of):			201			
oo ou, ficate be executed physician and s the bunk-transit edical Examiner	Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury c.									
	that initiated events resulting in death) Last	d								
eath certifor use a clan/M										
het the death certified by the attending detached for use a Physician/M	Part II. Other significant conditions	contributing to death b	23b. Did to		ributs to the causs of death?  B Probably 4 Unknown					
iclen: The law requires that the death certificate has been signed by the attending fector, page 2 should be detached for use a Be Completed by Physiclan/M	Copp			24a. Was a perior	24a. Was an autopsy performed?  24b. Were autopsy find available prior to completion of ceu of deeth?					
vital nec stellan: The law stellificate has b director, page 2 s						1 D Y	es 20 No	1□Yes 2□No		
slan: Jan: Jan: Be C	25. Wes case referred to medical				26. Place of Deal					
hysicle his cer il direc	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2 ER/Out	patient 3 DOA Ott	her /		ence 8 Other	(Specify)		
ding Phy h. After thii funeral tion: T	27. Manner of Death  1 Netural 5 Pending investigation	28a. Date of Inju	ry 28b. Tie	ma of 28c. Inju			ow injury occurred	. , . , ,		
To the Hospital or Attending Physician: The Iswithin 24 Hours after death. To the Funeral Director: After this centificate ha completely filled in by the funeral director, page Medical Certification: To Be Com	2 Accident investigation 3 Suicide 6 Could not I 4 Homicide determined	28e. Piece of In	jury - At home, fam c. (Specify)	m, street, factory, office		28f. Location (S City or Town	treet and Number n, State)	or Rural Route Number,		
he Hospita in 24 hours he Funeral pletaly fille			examination and/	death occurred at the til for investigation, in my						
ithin of the omple omple	29b. Signature and title	The country at	100	29c. Licens	se number	2	29d. Date signed (	(Month, Day, Year)		
- 5 - 0	· /lu	0		0	13981	3	5/17	1/84		
	30. Name and address of person who	completed ceuse of c	leath (Item 23e) (T	iype, Print)	nue	Splis	sono	21824		
State Registrar	31. Date filed (Month, Dey, Year) MAY 2 8 1	32. Registr	ar's Signeture	G. Span	61					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND ITEM#17 PER F.H. 5-28-99 G771 J.A. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3 Time of Death **Physician** 2 d 19999 Helen E. Thomas 9:27 p.m May /Medical 4a. Facility Nama (If not institution, giva street and numbar) 4b. City, Town, or Location of Death
Baltimore 4c. County of Death
TOWSON Examiner GREATER BALTIMORE MEDICAL CENTER 5. Social Sacurity Number 7. Aga (In yrs. last birthday) If Under 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 1925 Seirthplaca (Stata or Foraign Country) WashingtonDC **Funeral** Days 1 M 2 F Months Hours 74 220-16-8816 Director Usual Rasidance of Dacedant 10b. County 10c. City. Town or Location 10d. Insida City Limits 1 ☐ Yas 2 ☐ No Director MD. Baltimore Lutherville 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? ò must be 150 Westbury Rd. 21093 USA Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Give Was Dacadant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Navar Marriad 2 Marriad 1 ☐ Yes 2 ▼ No Specify: þ Specify: White 3 ☑ Widowed 4 Divorcad Be Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Spacify only highast greda complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Insurance Underwriter Insurance 17. Fathar's Name (First, Middla, Last) 18. Mothar's Neme (First, Middla, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental Thompson Rodolphus Helen Simpson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Numbar or Rural Routa Numbar, City or Town, State, Zip Code) Mrs. Barbara Gronning/DTR 13933 Jarrettsville Pike, Phoenix, MD. 21181 If Item 27 20b. Place of Disposition (Nema of cematary, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Spacify) Dulaney Valley Mem.Gdp.5-28-99 Timonium,MD. 22. Nama and Addrass of Facility
Ruck Towson Funeral Home,
1050 York Rd. Towson, MD. 21. Signature of Funeral Service Lightsee lnc. 21204 e of complications that caused tha daath. Do not enter the moda of dylng, such as cardiac or raspiratory arrast, List only ona cause on each lina. Approximata Interval Batween Onset end Daath **Physician** tmmediete Ceuse (Finat disaasa or condition rasulting in death) FIBRILLATION /Medical VENTRICULAR 3 MWUTES Examiner Due to (or es e consequence ot)
EMPHYSEMA Examiner The law requires that the death certificate be executed Saquentially list conditions, if eny, laading to immadiata causa. Entar Undarlying Causa (Diseesa or Injury thet Initiated avants rasulting in daath) Last the burial-tran HEART FAILURE P.O. Box 68760, Physician/Medicai usa as Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ director, page 2 should be 24b. Were eutopsy findings availabla prior to complation of ceusa of daath? Completed 24a. Wes an autopsy performad? 1 ☐ Yas 2 No 1 ☐ Yas 200No of Vital Physician: 25. Was casa referred to madical axeminar? Be 26. Pleca of Death (Check only one) Hospitat 1 ☐ Inpatiant 2 ☐ Propertient 3 ☐ DOA Othar: 4 Nursing Homa 5 Residance 6 Othar (Specify) 1 ☐ Yes 2 No 9 this 27. Mennar of Deeth Dete of tnjury (Month, Day Yaar) 28b. Tima of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred al or Attending P after death. I Director: After t Division 5 Panding invastigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be detarmined 3 Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) in by 28a. Place of injury - At homa, farm, straat, factory, office building, etc. (Spacify) 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital cartifying Physician: To the bast of my knowledge, death occurred et the tima, date and place, and dua to tha causa(s) and mennar as statad.

| Medical Examinar: On the bast of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and mannar statad. 29a. Cartifiar Medicai completaly 29b. Signature and title of certifige 29c. Licansa number 29d. Data signad (Month, Day, Year)

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6501 N. CHARCESST. TOWSON, MD21204

Registrar

State

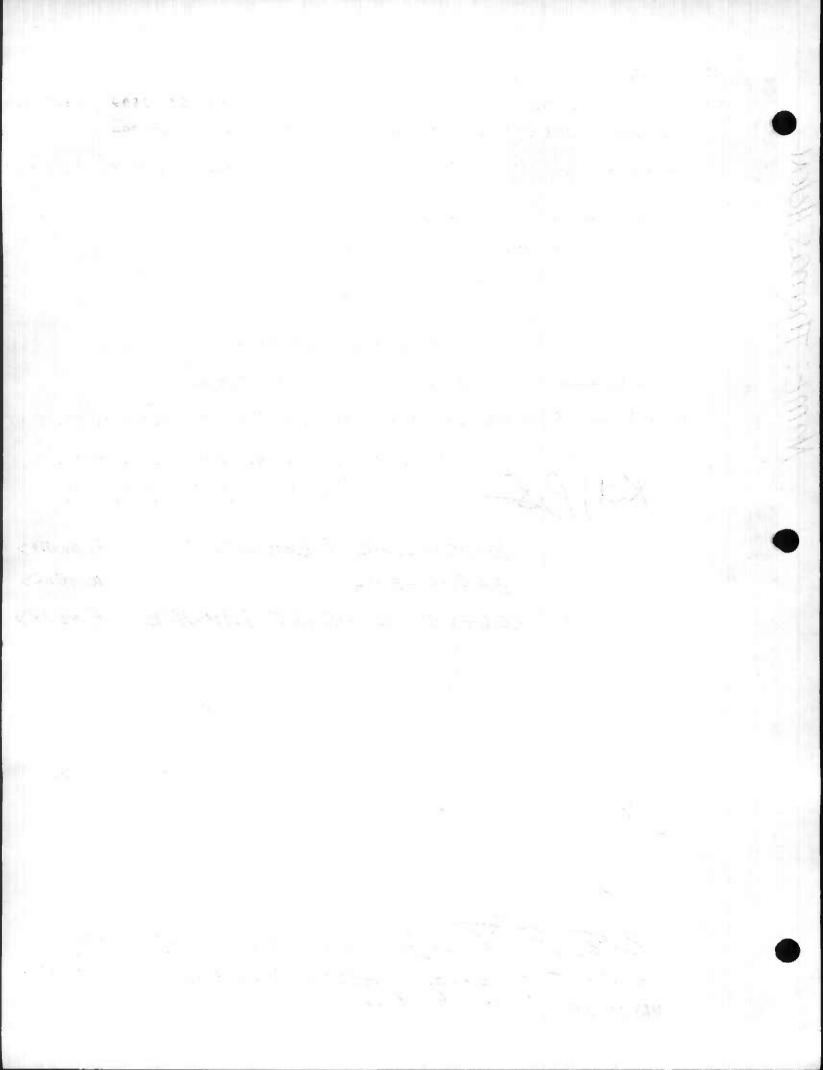
30. Name and eddrass of person who completed cause of death (Itam 23a) (Type, Print)

\*\*SGITH
31. Data filed (Month, Day, Year)

MAY 28 1999

SIVERTSON

32. Registrar's Signature



### Please Type or Print in Biack Indelibie Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Walter A. Trocki 22, 1999 4c. County of Death 1999 May 4:30 PM 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death HCR Manor Care Baltimore If Under 24 Hrs. 8. Da Hours Min. (M Baltimore If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2□ F Oct. 02,1921 Poland 213-16-5080 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore Essex 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 2104 Oakland Ave. 21220 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Carpet Installer Own Business 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Franciszek Aniela Widomski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Alice Coleman/ Daughter 2104 Oakland Ave., Balto., Md. 21220 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 5-26-99 1 ☐ Burial 2 【Cremation 3 ☐ Removal trom State 4 ☐ Donation 5 ☐ Other (Specify) Balto-Wash-Crematory Laurel, Md. 21. Signature of Fundral Segrice License 22. Name and Address of Facility Bradley-Ashton-Matthews Funeral Home, Inc 2134 Willow Spring Rd., Balto., Md. 21222 rall 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset end Death Cardia L 1-2 lus Immediate Cause (Finel disease or condition resulting in death) 12-14 mook Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? (andi ampo T ochemic 1 Yas 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Wes an autopsy 1□ Yes 2010 1 Yes 24 No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O. Vital Attending Physician: o Ne Hospital or Attending n 24 hours star death. Ne Funerel Director: Aft pietely filled in by the fur

Baltimore, Maryland 21215-0020

permit. Peges 1 and 2 should be filed within: Department of Health and Mental hygiene. Important: If Item 27 is marked other than "I any Injury or other traumatic event, ma Heal

Physician

/Medical

Examiner

**Physician** 

/Medical

Examiner

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Physician/Medical Examiner

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Certification: To

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To the Hosp within 24 hos To the Fune completely fi

**Funeral** 

Director

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Registrar **DHMH 16 Rav 6/95** 

MAY 2 8 1999

29b. Signature and title of certifier M.D

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

wa & sporks

MALIKA WASBEM, 404. EASTERN BLVD. MD-21221

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as atated.

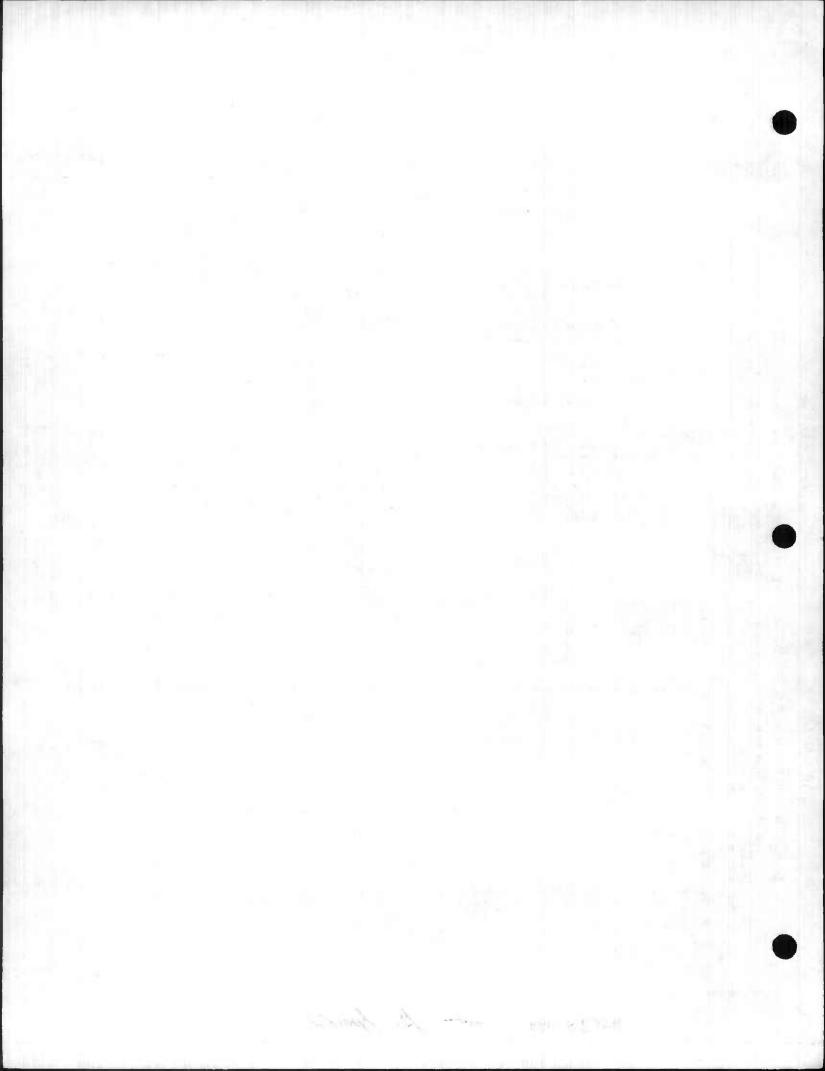
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D-38754

29d. Date signed (Month, Day, Year)

05-24-99



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death **Physician** 1:35 AM Carrie Ellen Toomey MAY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Nema (If not Institution, give street and number) **Examiner** Baltimore StellaMarisHospice - Mercy Hospital 7. Age (In yrs. last birthday) If Under 1 Year 8. Dete of Birth (Month, Dey, Year) Dec 17 1923 Birthplece (State or Foreign Country) 5. Social Security Number Months Days Hours 1□ M 25 F 75 212-22-0149 Kentucky **Director** Usuel Residence of Decedent with the Merylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23s or 28s-f show other trsumstic event, the Moulest Exemples must be notified at MD Baltimore Baltimore 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 1001 Elton Road 21224 USA Funeral 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. 11. Meritel Stetus Black, White, etc. permit. Pages 1 end 2 should be filed within 72 hours efter Department of Heelth end Mentel Hygiene. Important: If Item 27 is marked other than "natural", or ite 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 □XWidowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highast grade complated) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker 5th own home 18. Mothar's Name (First, Middle, Maiden Surnama) 17. Father's Neme (First, Middla, Last) Sam A. Berry 10 Minnie C. Thompson 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Betty Scranton / daughter 2526 Lange Street Baltimore Md. 21224 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 Buriel 2 □ Cremetion 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify) MeadowridgeCemetery 5/29/99 Baltimore Md. eny injury 22. Name and Address of Facility 21. Signeture of Funerel Service License Connelly Funeral Home of Essex plicetions that caused the deal to potenter the mode of dying, such as cardiac or respiratory errest, one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical marin 245tric Concer Examiner Due to (or es e consequence of) Examiner hysician end the buriel-transit requires that the death certificate be executed Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es e consequence of): Box 68760 Physician/Medical thet initiated events rasulting in death) Lest Due to (or es e consequence of) 58 USB 1 23b. Did tobacco use contribute to the cause of death? ed by the deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, þ 2 24b. Were eutopsy findings available prior to Completed 24e. Wes en autopsy performed? completion of cause of deeth? page 2 s 1 ☐ Yes 2 ☐ No certificate 26. Place of Deeth (Check only one) ITA MAIS At Mercy or Attending Physician: 25. Was case referred to medical exeminer? Other: 4 | Nursing Home 5 | Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatianf 2 ER/Outpatient 3 DOA After this funeral 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how Injury occurred 27. Manper of Deeth 28b. Time of Certification: 1 ☑ Naturel ☐ Accident 5 Pending s efter death. 1 Yes 2 No 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 24 hours Cartifying Physicien: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated. | Madical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner stated. 29e. Certifier edical (Check only one) within 2 the 29d. Data signed (Mopth, Day, Year) 29b. Signeture and title of certifier 040854

State Registrar

Toomey, Careie

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30. Nerre end eddress of pe

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32. Registrer's Signeture

son who completed cause of deeth (Item 23e) (Type, Print)

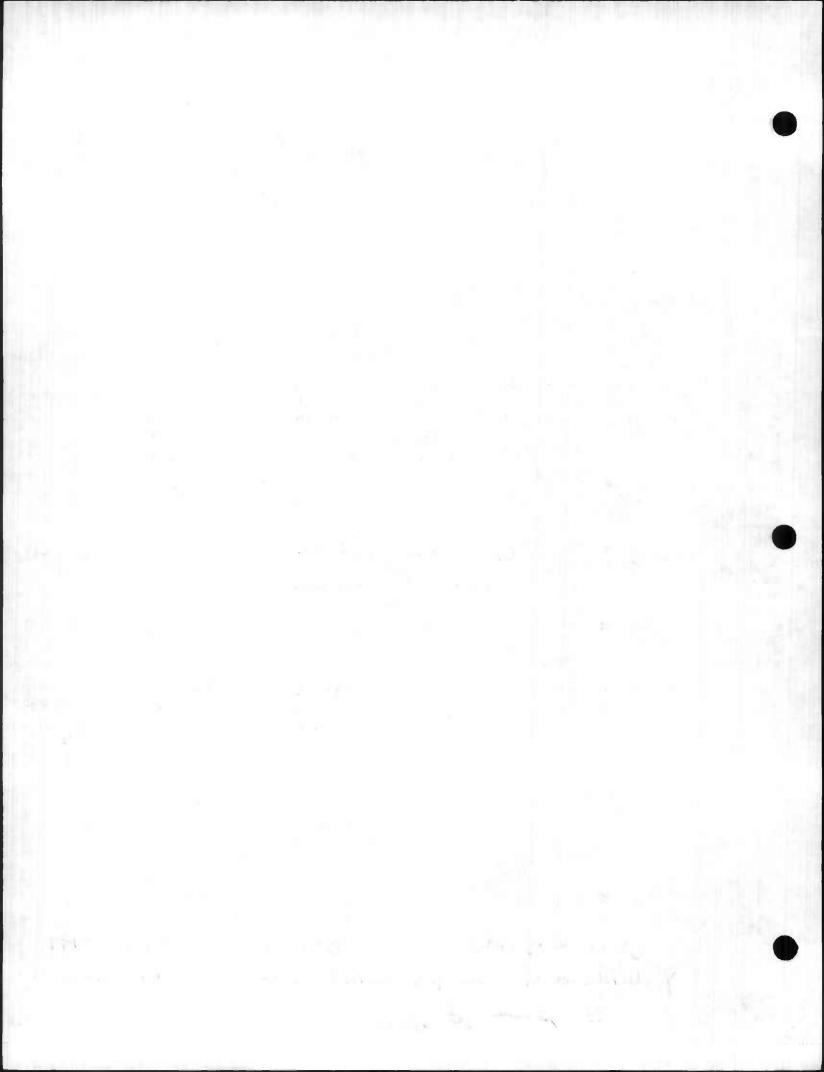
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# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

by Funeral Director	233–44–0313  Usual Residence of Decedent  10a. State 10b. County  MD Anne A  10e. Street and Number  1321 Emerald La:  11. Marital Status	ve street and number) ane  Sex 7. Age 11 M 2 F 7.	(In yrs. last birth  10c. City, Town  Severn	hday) If Unde Months	r 1 Year	4b. City, Town, or I Severn	Month May  Location of Death	24 199 4c. County o	f Death
ph Funeral Director	1321 Emerald L  5. Social Security Number 233–44–0313  Usual Residence of Decedent  10a. State 10b. County  MD Anne A  10e. Street and Number  1321 Emerald La.  11. Marital Status	ane Sex 7. Age 111 M 20 F	10c. City, Town	Months	r 1 Year	Severn			
by Funeral Director	5. Social Security Number 233–44–0313  Usual Residenca of Decedent 10a. State 10b. County MD Anne A 10e. Street and Number 1321 Emerald La: 11. Marital Status	Sex 11 M 2□F 7. Age 12 M 2□F 7.	10c. City, Town	Months					Assum de 1
by Funeral Director	233–44–0313  Usual Residenca of Decedent  10a. State 10b. County  MD Anne A  10e. Street and Number  1321 Emerald La:  11. Marital Status	rundel	10c. City, Town	Months				Anne	Arundel
by Funeral Director	10a. State 10b. County MD Anne A 10e. Street and Number 1321 Emerald La. 11. Marital Status					If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da May 26		9. Birthplace (State or Foreig Country) Vest Virginia
by Funeral Director	MD Anne A  10e. Street and Number  1321 Emerald La  11. Marital Status			or Location		-			10d. Inside City Limits
by Funeral	1321 Emerald La		DEVELII				of the same	100	1 ☐ Yes 2√ No
by D		ne		Code 2114	4		10g. Citizen of What Country?  USA		
	1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 X Yes 2 ☐ N If Yes, Give Year or Detes: ]	0	13. Was Dece If Yes, spe 1  Yes		lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	14. Race Black Specify:	- American Indian, , White, etc. White
Completed	15. Decedent's Elementary/Secondary (0-12)	ducation rade completed) College (1-4or 5	F)	Decedent's Usu (Give kind of wo life. DO NOT u	cedent's Usuel Occupation ve kind of work done during most of work to DO NOT use retired)		king	16b. Kind of Bus	
	12 17. Father's Name (First, Middle, Las	2	DI	ICMIIasu	11	18 Mother's Nan	ne /First Middle	Constru Maiden Sumame	
m	George Washingto					Louise			
2	19a. Informant's Name/Relationship		19h	Mailing Address	s (Street	and Number or Ru			itate Zin Code)
	Rose Marie Tren					Lane, Se			nate, Esp Coccey
;	20a. Method of Disposition	(,	20b. Place of	Disposition (Na	me of		Date		city or Town, State
	1 ☐ Burial 2 【 Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Special			crematory or o			05/25	Baltimor	re, MD
450	21. Signature of Poneral Service Lice	I Shoot	1/1	Hard	esty	ss of Facility Funeral ly Avenu	Home, F	A.	21401
n	23a. Part1. Enter the disease, of cor shock, or heart failure. List only	nplications that caused y one cause on each lin	the death. Do no						Approximete Intervel Between Onset and Death
	Immediata Cause (Final disease or condition resulting in deeth)	· Gr	Due to (or es a c	s l	iv	er			3 yrs
5		00	Due to (or es a c	onsequence of):	1	10			0
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	b. //	Due to (or es a co	onsequence of):					1
2	Cause (Diseese or Injury that initiated events resulting in death) Last	С	Due to (or as a consequence of):						
Physician		d			-				
S C	Part II. Other significant conditions	contributing to death bu	t not resulting In	the underlying o	ause giv	ven in Part I.	23b. Dld	tobacco use cont	ribute to the cause of death
by Phy							10	Yes 211 No	3 Probably 4 Unknow
eted								an autopsy ermed?	24b. Were autopsy findings available prior to completion of cause of death?
E							10	Yes 200 No	1 ☐ Yes 2 ☐ No
0 2	25. Was case referred to medical				_	26. Place of Dec	th (Check only o	one)	
To Be Comp	axaminer? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpaties	nt 2 ER/Out	patient 3□ D	OA Oth	NAC .	-	dence 6 Other	(Specify)
tion:	27. Manner of Death  1 Watural 5 ☐ Panding 2 ☐ Accident investigetic	28a. Date of Injur (Month, Dey	Year) 28b. Ti	ime of jury M	28c. Injui Wo	y at rk? Yes 2 □ No	28d. Describe how injury occurred		
Certification:	3 Suicide 6 Could not l determined		ry - At home, fen (Specify)	m, street, fector	y, office		28f. Location ( City or To		r or Rurat Route Number,
		hysician: To the best of miner: On the basis of and manner sta	examinetion and						
2 2	29b. Signature and title of cartifier			29	c. Licens	se number		29d. Date signed	(Month, Day, Year)
	· Orank	on M.D	,		D	39505		may:	25, 1999
3	30. Name and address of person who	completed cause of de	ath (Item 23a) (I	Type, Print)	n fe	wy, G	lan Bu	mie	25, 1999 MD. 21061



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Man 10:00 am Virginia Ruth Tilghman 4e. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Charlestown Catonsville Baltimore Care Center 5. Social Security Number If Under 1 Yaar | If Under 24 Hrs. 6. Sex 8. Data of Birth (Month, Day, Year) 7. Age (In yrs. last birthdey) Birthpleca (Stata or Foreign Country) Days 1□ M 2⊡ F Months Hours Yrs. 218-01-4311 Nov. 13 Usual Rasidance of Dacedant 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 ☐ No MD Baltim∩re Catonsville 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 715 Maiden Choice Lane 21228 U.S.A. 12. Was Dacedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indien, Black, Whita, etc. 1 Navar Married 2 Marriad 1 ☐ Yas 2 ☐ No Specify: Specify: White 3. Widowad 4 □ Divorced 15. Decedant's Education (Spacify only highast grade complated) 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) 12 Legislative Assistant Md State Government 17. Fether's Nema (First, Middle, Last) 18. Mothar's Name (First, Middla, Maldan Surname) George Eminhizer Gladys Giesland 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Route Numbar, City or Town, State, Zip Coda) 366 Beech Down Drive Chantilly, VA 20151 of Disposition (Nama of Disposition (Nama of Data 20c. Location - City or Town, State Richard E. Tilghman Son 20a. Mathod of Disposition 20b. Place of Disposition (Nama of camatary, cramatory or other place) 1 ☐ Buriel 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donetion 5 ☐ Other (Spacify) 6/1/99 Woodlawn, MD Woodlawn Cemetery 21. Signature of Fundral Service Licensee 22. Name and Addrass of Facility Witzke Funeral Homes, Inc. 21228 1630 Edmondson Avenue, Catonsville, MD no 23e. Pert1. Enter the disaase, or complications that caused the deeth. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failure. List only one cause on each line. Approximata Intervel Between Onset and Death Immediete Ceuse (Finel diseesa or condition rasulting In daeth) Metastatic months Sequentially list conditions, if any, leeding to immadiata causa. Entar Underlying Cause (Disaasa or Injury that initiated avants rasulting in death) Last Dua to (or es e consequence of): Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to complation of cause 24e. Wes en autopsy parformed? 1 Yas 2 W 1 ☐ Yes 2 1 Mo 26. Place of Deeth (Check only ona) Other: 4 Nursing Homa 5 Rasidanca 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

The law requires that the death certificate be executed bunial-trai the eral Director: After this certificate has been si lilled in by the luneral director, page 2 should Attending Physician: Name: V

death.

Physician/Medical þ Completed Be 10 Medical Certification: To the Hospital or Att within 24 hours after of To the Funeral Direct completely lilled in by

Physician

/Medical

**Examiner** 

**Funeral** 

Director

ns 23a or 28a-f show

Items 2

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiane. Important: if item 27 is marked other than "natural; or item any injury or other traumatic event, the Medical Expenses

**Physician** 

/Medical

**Examiner** 

Director

Funeral

Completed by

Be

the Marylend

21215-0020

Baltimore, Maryland

25. Was casa rafarred to medical 1 Yas 2 No

27. Manger of Daath 1 Natural 5 Panding Invastigation 2 Accidant 3 Sulcide

6 Could not be 4 Homicide

28a. Data of Injury (Month, Dey Year) 28a. Plece of Injury - At homa, farm, streat, factory, office building, etc. (Specify)

28b. Tima of

28c. Injury at Work? 1 ☐ Yas 2 ☐ No 28d. Dascribe how injury occurred

28f. Location (Street and Number or Rurel Routa Number, City or Town, Stata)

1 Certifying Physician: To the best of my knowledge, deeth occurred et tha tima, dete and plece, end due to the ceuse(s) and manner es stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, daeth occurred at tha tima, data and place, and dua to the cause(s) and mennar stated. (Check only one) 29b. Signatura end titla of certifler

29a. Certifian

29c. Licansa number

29d. Data signed (Month, Day, Year)

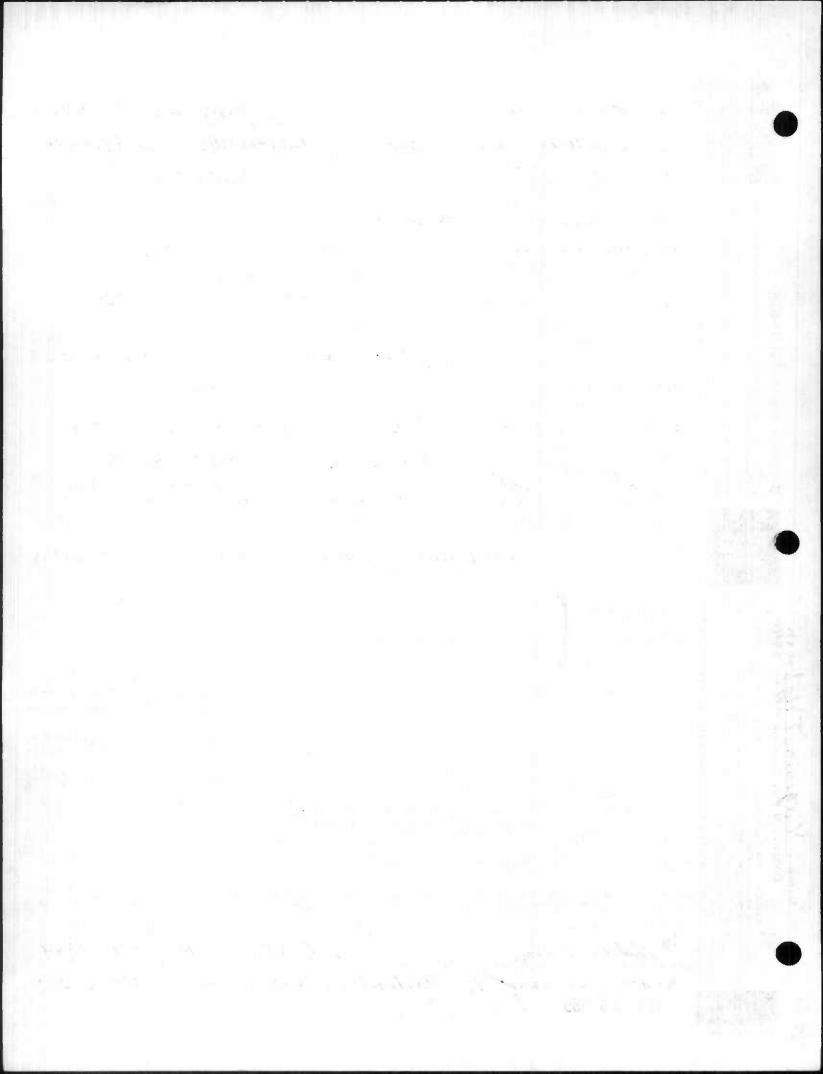
30. Neme and addrass of parson who completed causa of daath (Item 23e) (Type, Print)

D 51051

av 7// M 32. Registrar's Signature Salazar

Maidanchoice Lane, Catomville, MD, 2/228

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AmendedItem#20b perFH G771 5/28/99 EW Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month May **Physician** 7 9999 2:08 p.m Whitaker VIRGINIA /Medical 4c. County of Death

TOWSON 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE GREATER BALTIMORE MEDICAL CENTER If Under 1 Year If Undar 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 1□M 2XF 66 Yrs. 212-30-2046 Usual Residence of Decedent **Director** 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits nk: Whitaker, Dirgin Ma 1 ☐ Yas 2 ☑ No Director 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Code 7 is marked other than "natural", or items 23s or traumstic event, the Medical Examiner must be a Funeral 12. Was Decedant Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Mexican, Puerto Rican, atc.) Race - American Indian, Black, Whita, atc. 11. Marital Status 1 ☐ Yes 2 No If Yas, Giva Year or Dates: 1 Never Married 2 Married Specity: White 1 ☐ Yes 2 No Specify: p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT, use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Stebbins & Andurson Elemantary/Secondary (0-12) College (1-4or 5+) Secretar 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be 2 should be f and Mental F 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 end 2 I imovium. gemoor Health Hem 27 i Rd. 20b. Placa of Disposition (Name of cemetery, crematory or other place) Date June 20c. Location - City or Town, State 20a. Method of Disposition Department of I 1 Burial 2 Cremation 3 Removal from State 9 4 ☐ Donation 5 ☐ Other (Specify) any Injury IIMONIUM 22. Nama and Address of Facility Evans Funeral Chapel Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one ceuse on each line. 21093 Approximate Interval Between Onset and Death **Physician** Responatory Failure Immediate Cause (Final disease or condition rasulting in death) /Medical Examiner Due to (or es e consequence of) Examiner WEEKS HRDS ilcian and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieled events resulting in death) Last Due to (or as e consequence of): 3WEEKC HIP FRACTURE physician sthe burial Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequenca of): 88 esn Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed t by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 1 Yes 2 No or Attending Physician: 25. Wes case referred to medical exeminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation Natural 1 Yes Funeral Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) To the To To the F 29b. Signature and title of certifier 29c. Licansa number 29d. Date signed (Month, Day, Year) 5 27 99. 52279 6701 Noharles Street M1721204 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

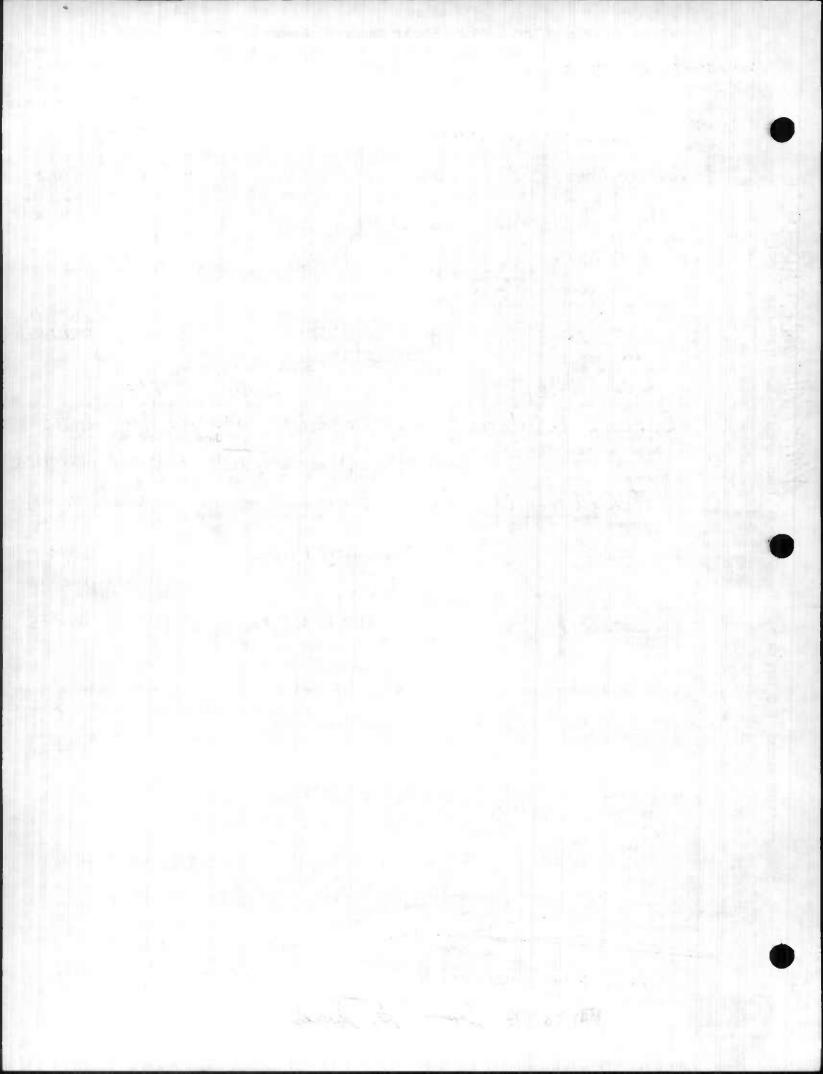
SCIRAN H. BACASUBRAMANIAN G BMC JRIRAM

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** Month Year 4:10 Au LEDAD WATTON 1999 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Hospital Northwest Rompallshun BALHUOR If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth
Months Deys Hours Min. (Month, Dey, Year) 5. Sociel Security Number 6. Sex 12 M 2□ F 9. Birthplece (State or Foreign Country)
Caro (in the country) 7. Age (In yrs. last birthday) **Funeral** 249-22-4366 79 Yrs. Director Usuel Residence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f shot traumatic event, the Moulcal Examiner must be notified at 1 Tes 2 No BALFIMORE Director Marylows 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? KEYWORTH AUS 2414 USA 21215 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Yeer or Dates: 11 Maritel Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. Peges 1 and 2 should be filed within 72 hours after or ent of Health end Mental Hygiene. not: If Itam 27 Is marked other than "natural", or Ital 1 ☐ Never Merried 2 ☐ Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black by 3 Widowed 4 Divorced Completed 15. Decadent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry THOMAS + HOWARD Elementery/Secondary (0-12) College (1-4or 5+) LABOVEN Distributing Co. 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Watson SR KOSEHA LEON 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 4207 Phillis Watson Drughter ROAD Baltiner, ald CRESTHEIGHS a. Method of Disposition

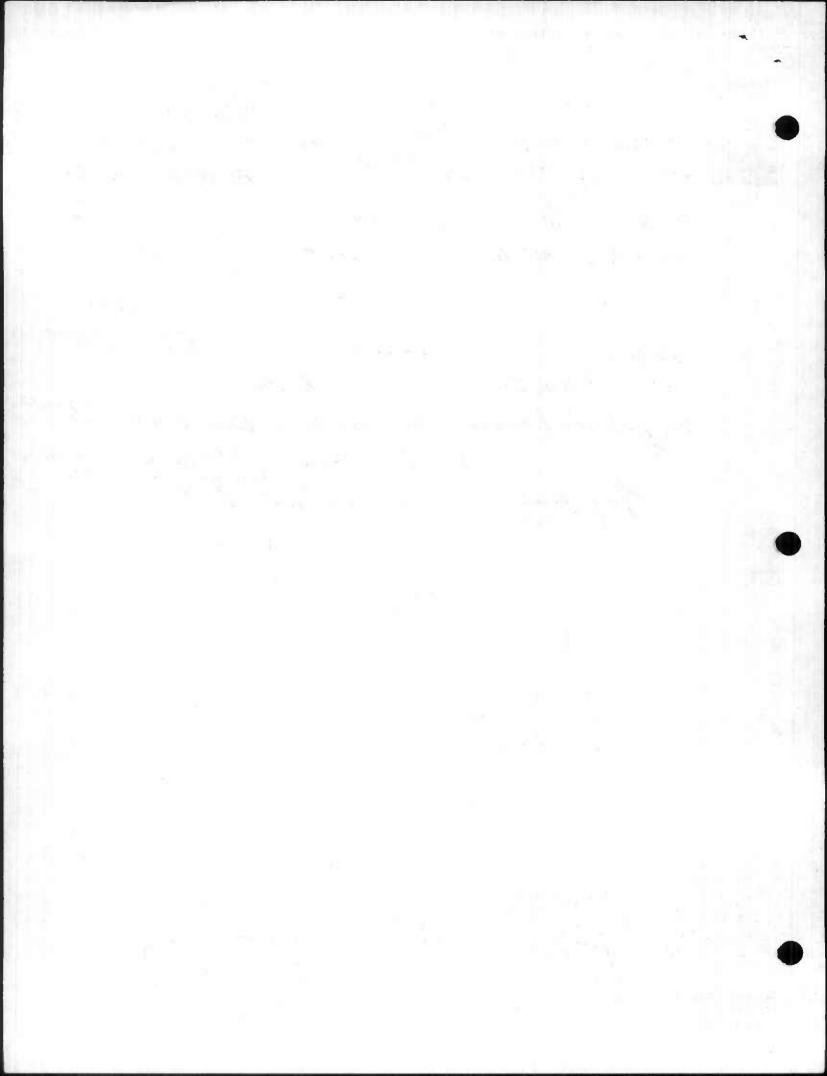
Burial 2 Cremetion 3 Removal from State 20b. Place of Disposition (Neme of cemetery, cremetory or other place 20c. Location - City or Town, State 0 permit. Pege Department of Important: If any Injury or once. Hemorial 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility CHA TULAN-HARRII 21. Signeture of Funeral Service Lightson REISTEASTUM RIAD 23a. Partt. Erfor the dh ease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock or heart failure. List only one cause on each line. Approximete Interval Betwe Onset end Deeth **Physician** /Medical Immediate Ceuse (Final Lou disease or condition resulting in deeth) Examiner physician and s the burial-trans Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Lest Due to (or as a consequenca of) be exec Physician/Medical Due to (or as e consequenca of): been signed by the e should be detached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2□ No 3 Probably 4 Unknown Disaider 24b. Were eutopsy findings aveilable prior to Completed 24e. Wes en eutopsy performed? completion of cause of death? certificate hes 1 Yes 2 11 No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: 25. Wes case referred to medical exeminer?
1 ☐ Yes 2 ☐ No Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Pinpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of Certification: 28c. Injury et Work? After 1 Natural 5 Pending Investigation death. To the Hospital or Attendit within 24 hours efter death.
To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, tactory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyelclan: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as stated.

I Certifying Phyelclan: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner stated. 29a. Certifier edical (Check only one) 29b. Signature and title # 29d. Dete signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) MD 1 mps Rin 31. Dete filed (Month/Day, Yeer) 32. Registrer's Signature

Registrar

State

2 8 1999



Certificate	of Death
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. AM	END	TIEM#8 PER F.R. G/	/1 5-	20-33 0.	л.	Ce	rtificate	Of .	Death			Reg. No.		1 307,00
		1. Decedent's Neme (First, Mic	idie, Las	11)							2. Dete of De Month		Year	3. Time of Death
Physi /Med		Helen Jane Wedemai	1								May		1999	12:20 AM
Exam		4a Facility Name (If not Institu	ion, give	street and nu	m <i>ber)</i>				4b. City, To	wn, or L	ocation of Death	_	ty of Deeth	
		Gilchrist Center							Tows			Bal	timore	Co.
Funera	ıl	5. Social Security Number	6. S	ex □M 2[3(F		s. last birthday)	If Under 1 Months (	Yeer	If Under:	24 Hrs. Min.	8. Date of Bir (Month, De	th 1919	9. Birth	place (State or Foreign
Directo	r	212-01-3689		UM 2017	80	Yrs.		10.3			Feb. 19,	1999	Baltin	more, Maryland
2 *-	with the Maryland a or 28a-f show the notified at Director	Usual Residence of Decedent  10a. Stete 10b. Cour	ntv		10c. C	City, Town or Lo	ocation							10d. Inside City Limits
fant fant			,	e Co.		owson								1 ☐ Yes 2 ☐XNo
288	Directo	10e. Sfreet and Number	CINOI	c w.		OWSOIT	10f, Zip C	nde				10g. Citizen of	What Cou	intry?
the state		8301 Carrbridge C	imla					204						of America
The 2	Funeral	11. Merital Status	rere	12. Wes Dec	edent Ever in	U,S. 13.				gin? (Sp	ecify Yes or No Rican, etc.)			ican Indian,
or the	Ē	1 Never Merried 2 M	arried	Armed Fo	2 X No					, Puerto	Rican, etc.)		eck, White,	etc.
hours after hursf., or h	by	3 Widowed 4 □ Divord	ed	If Yes, Gi	ve Detes:		1 ☐ Yes 2 ☐	No	Specify:			Speci	"y: Whi	te
21215-0020 d within 72 hours at giene. ir then "netural", or the Medical Exem	Completed	15. Deced (Specify only hig	ent's Ed	ucation		16a. Dece	dent's Usuel (	Occup	oation	of work	rino	16b. Kind of I	3usiness/ir	ndustry
121 within then.	di	Elementery/Secondary (0-12	T	College (	1-4or 5+)	life.	kind of work DO NOT use			Or WOIN	arg			
	S	12		n/	a		Book Ke	epe					I Jewe	lers
D STEP	8	17. Father's Neme (First, Midd									e (First, Middle,	Meiden Sume	me)	
New	5	Nelson Reynolds Co	-						Mattie					
Maryland 42 should be fla th and Mental Hy 7 is marked oth traumatic event		19e. Informent's Neme/Reletion			,						al Route Numb			
- 5525		Mrs. Debby S. Har	er (	Daughter			Glenoak			irret	tsville,	Maryland 20c. Location		
Pages hant of it		1 X Burial 2 Cremetio			Stete	Plece of Dispo cemetery, crea	-		ce)	1_				
Baltimore		4 Donetion 5 Other	12	A	/ Ne	w Freeda			4 E 100a		/26/1999			
Ba med		21. Signature of Funeral Service Licenses 22. Name end Address of Fecility RUCK TOWSON FUNEral Home, 1050 York Rd. Towson, Md.											21204	
		/al	χ.	/an	401								,	
		23a. Part1. Enter the district shock, or heart feilur.	ist only	ne cause on	rum line.	eth. Do not en	er the mode of	of dylin	ng, such as	cardiac	or respiretory e	rrest,	- !	Approximete Intervel Between Onset end Death
Physician /Medica	_	Immediete Cause (Finel	1	//										70 110 00000
Examine		diseese or condition resulting in deeth)		a Mr	-JAM		An	2	Co	D.1	RE P	orunda		27
	ē				Due to	(or as a consec	quence of):	2						1.
betu	Examiner		•	b	7 S C	(or as a consector as a consector)	( ( )		7.12				1	67~
osso un an	EXS	Sequentially list conditions, if any, leeding to immediate cause. Enfer Underlying Cause (Disease or Injury			/ .	رسم المان المان	(uerica oi).		(, ,		<b>-</b> 9			1
X 68760, sertificate be executed ding physician and se as the bunal-transit	edicai	that infleted events	<	c	Due to	(or es e consec	Mence of):		007				-	bm
68 Filica	Pe	resulting in death) Last												
0 0 0 7	an/M			d									1	
Geath of attention of for un	Physician	Pert ff. Other elgnificant cond	tione co	entributing to de	eath but not re	sulting in the u	nderlying cau	se giv	ren in Pert I.		23b. Dld	tobecco use c	ontribute 1	to the cause of death?
P.O. that the de detached	Phy										10	Yee 2□ No	3 Pro	bably 4 Unknow
S, Fles that igned be det	by									_				
Vital Records, P stellan: The law requires that certificate hes been signed it rector, page 2 should be det	Completed											an eutopsy rmed?	- 61	Vere autopsy findings vailable prior to
Receisar responses be september 2002 sh	ple													ompletion of cause f death?
The i	Con										10	Yes 2 No	1	☐ Yes 2☐ No
Of Vital   Physician: The This certificate	Be	25. Was case referred to medi examiner?	-							of Deel	h (Check only o	one)		
Of Physic rithis or rail dire	2	1 ☐ Yes 25 No		Hospital: 1	Inpatient 2[	☐ ER/Outpatier	nt 3□ DOA	Oth	4 🗆 🗥 0	rsing Ho	ome 5 Resid	dence 6 🗆 O	her (Speci	whose in
	on:	27. Menner of Death 1 ☑Natural 5 ☑ Pen	ding	28a. Dete (Mon	of Injury th, Dey Year)	28b. Time o Injury	1	Wor			28d. Describe	how injury occu	irred	
Vision Attending r death. ector: After	cati	2 Accident inve	sfigetion				М	10	Yes 2 1	No				
	Certification:		mined	266. Pteca	of Injury - At ing, etc. (Spec	home, ferm, str cify)	reet, fectory, o	ffice			28f. Location (: City or Tox		iber or Rui	ral Route Number,
oral Ball		202 02-115-11												
Dir To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edicai	29e. Certifier 1 Certify (Check only 2 Medic	nng Phy al Exam	iner: On the b	asis of examin	owiedge, deet etion end/or in	occurred at vestigetion, in	my o	me, date en pinion, deel	a place, th occur	and due to the red at the time,	cause(s) end n date end place	and due	stated. to the cause(s)
To the within 2 To the	Mec	29b. Signature end title of certi	ier 7	and men	ner steted.		#9c. I	icens	se number			29d. Date sign	ed (Month	Day, Year)
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		30. Neme and address of person	Si wilo g	A LITH	se of death (Ite	om 23a) (Type,	BELLO	11	, He	8	1000	ion 1	40	21204
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Registrar

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**Physician** 

/Medical

Examiner

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**Funeral** 

Director

7 is marked other than "natural", or items 23s or 28s-f shot trsumstic event, the Modical Examinar must be notified at

should be filed within and Mental Hygiene.

Heelth Jem 27

**Physician** 

/Medical Examiner

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SES 950 for

death certificate be executed

Box 68760.

Examiner

Physician/Medicai

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Completed

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Certification:

29a. Certifier (Check only one) 29b. Signature

Peges 1 Important: If it any injury or c

### Please Type or Print In Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Louis J. Woods MAY 26 1999 3:00PM 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) OCt. 15, 1917 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (Stete or Foreign Hours Maryland 10 M 2 F 218-05-5400 81 Yrs. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside Ctty Limits 10a. State 1 ☐ Yes 2 ☐ No Maryland Baltimore Towson 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 913 Weatherbee Road 21286 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispento Ortgln? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 11. Maritel Stetus 1 Tyes 2 No If Yes, Give Year or Dates: WW II 1 Never Merried 2 Married Specify: White 1 ☐ Yes 2 ☐ No 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrical Electrician 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Louis J. Woods, Sr. Myrtle Realv 19a. Informent's Name/Retetionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Ruth L. Woods / Wife 913 Weatherbee Road Towson, Maryland 21286 20b. Ptece of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stete Hilltop Service Corporation6/1/99 Towson, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Puheral Service License 22. Name and Address of Fecility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 0 a 23a. Part1. Enter the disease shock, or heart failure that Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate intervel Between Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to 24a. Wes an autopsy performed? completion of cause of death? 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medicat exeminer? 26. Place of Deeth (Check only one) 1 ☐ Yes 2X No 27. Manner of Deeth Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpattent 3 DOA 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Coutd not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide

Division of Vital Records, Attending in 24 hour. ŏ

Registrar

32. Registrar's ignature 31. Date filed (Month, Day, Yeer)

A. GTZSI-1~21DER

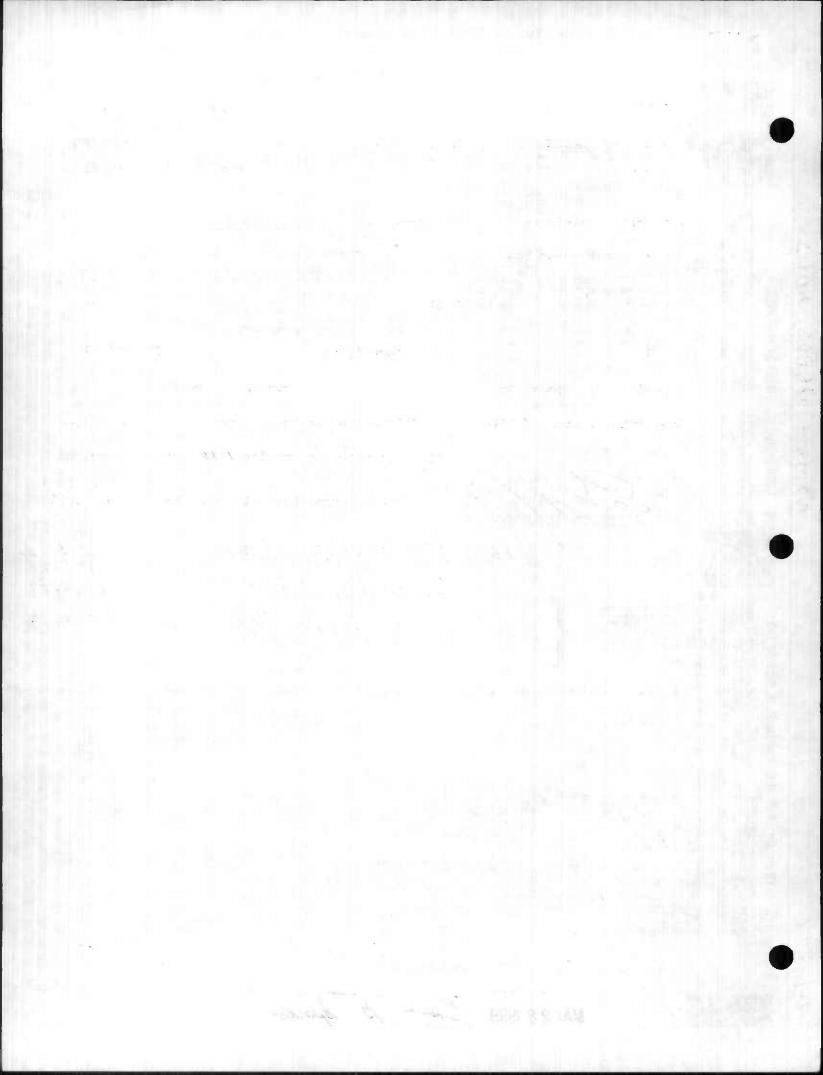
30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

3902-CANT2

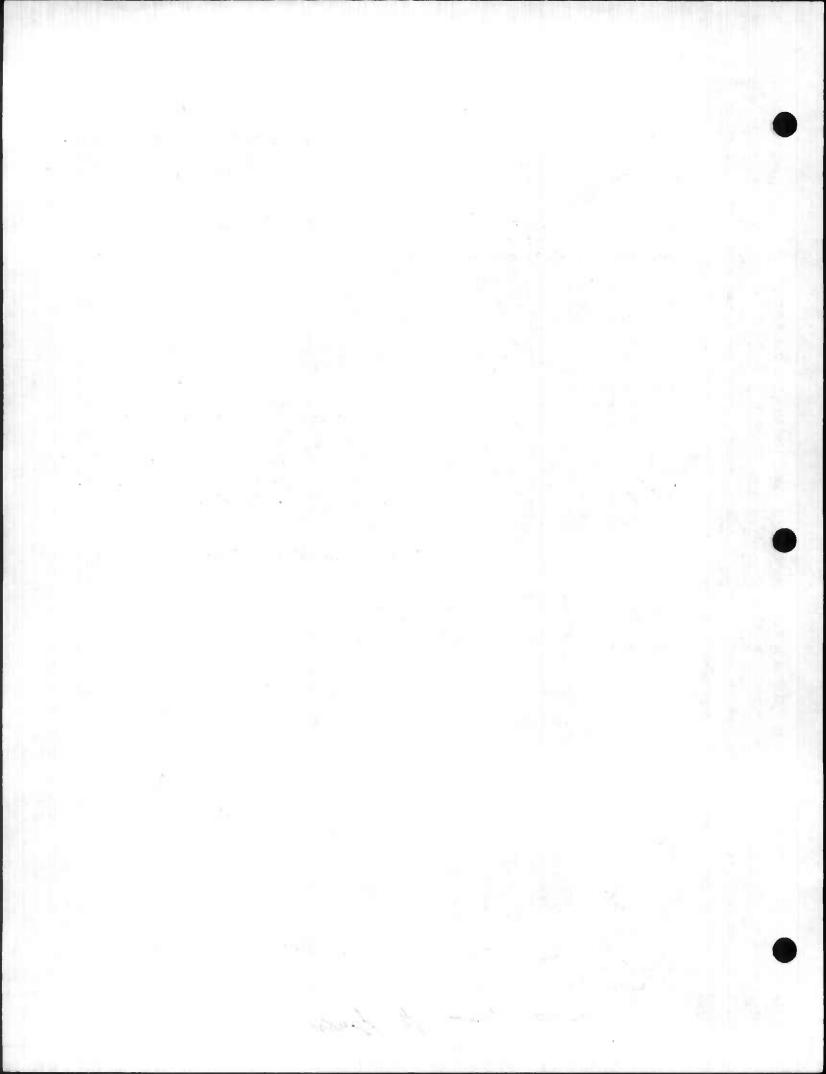
1/ Certifying Physician: To the best of my knowledge, death occurred at the time, dete end placa, and due to the cause(s) end menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

BURY RD,

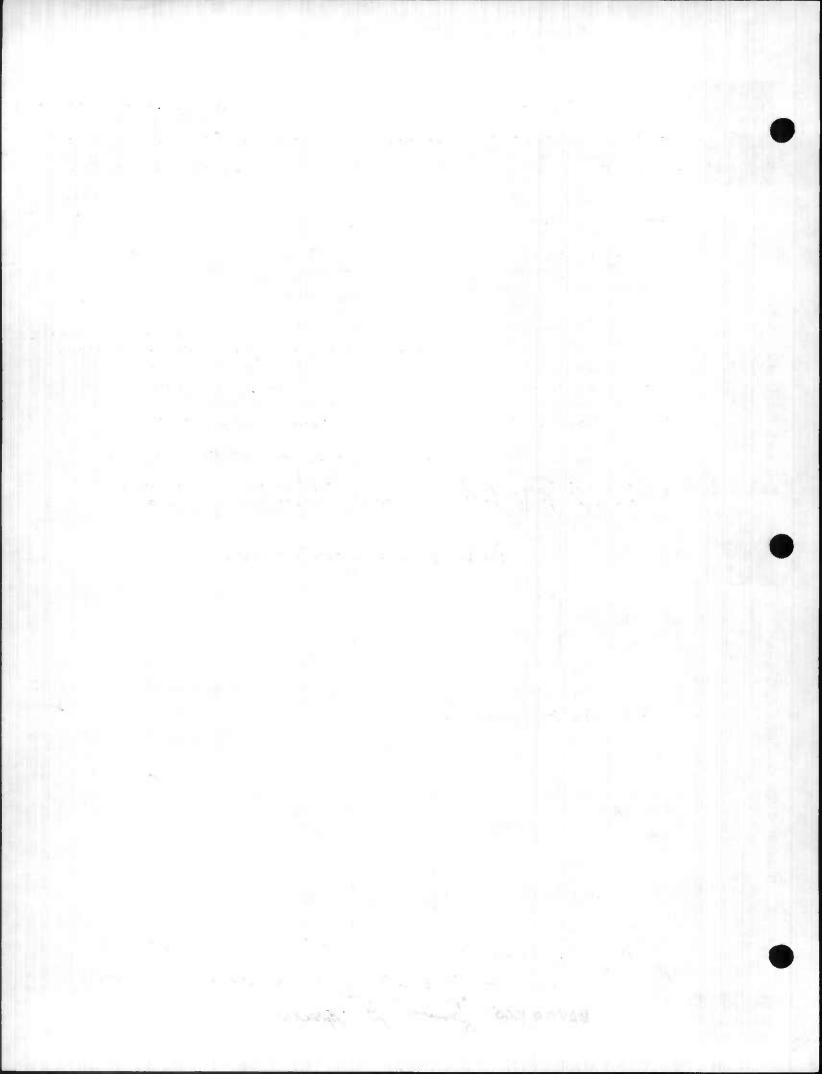


		State of Ma	aryland / Dep Ce	ertificate of		F	leg. No.	1	7160	
Physician /Medical	Decedent's Nama (First, Middla, La.	Ethel 1	L. Wentz			2. Data of Dea Month May 2	Day	Year	3. Time of Death 5:30 AM	
Examiner	4a Facility Nama (If not institution, giv	a street and number)	Herberts	Run#646	4b. City, Town, or L		,			
	Charlestown Retir			Williams A Vosco	Catonsv				e Co.	
Funeral Director	198-36-2055	ex 7. Ag	97 Yrs.	Months Days	Hours Min.	8. Data of Birth (Month, Day April	Year) 13,1902	9. Birthpi Coun Pen	laca (Steta or Foraign try) nsylvania	
9 Bu	Usual Residence of Decedent  10a. Stata 10b. County		10c. City, Town or I	Location				10	Od. Insida City Limits	
the Maryland 28a-f show notified at ector	Maryland Balt	imore		C	atonsvill	.e			1 ☐ Yas 2 🐼 No	
with the Ms a or 28a-f s Libe notified Director		rts Run#64	6	10f. Zip Code		,	10g. Citizen of W	hat Coun	try?	
23s santh	Charlestown Reti				21228		Unite			
in', or items 23e or 28er' show transfor must be notified at by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces?  1 Yes 2 N If Yes, Give Year or Dates:		. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No		pecify Yas or No- Pican, atc.)	14. Race Black Specify:	k, Whita, a	an Indian, atc. 'hite	
	15. Decedent's Ed			edent's Usual Occu			16b. Kind of Bus	sinass/Ind	lustry	-
ver then "neturn rt, the Medical.] Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5	lifa	re kind of work done DO NOT use retire	during most of world)	king				
Con	12 Years	3 Years	Re	gistered			Nursir	2		_
fo Be	17. Father's Nama (First, Middle, Last)				18. Mother's Nam	Boecke		a)		
	Stewart Seyler  19a, Informant's Name/Ralationship (	Firms Print)	105 145	ling Address (Street				Ctata Zia	Codel	-
er traum	Ann Elizabeth We			2 Bonn Dr						
other	20a. Method of Disposition		20b. Place of Disp	position (Nama of	201	Deta	20c. Location - (	City or To	wn, Stata	-
7, 04	1 Donation _ S ☐ Other (Specific			ematory or other pla se Cemete		1999	York, E	PA 1	7403	
important: If any injury or anna.	21. Signature of Fundal Service Licen	1-1-1	1	22. Name and Addre Duda-Ruc	- 1	Home o			nc.	
	23a. Part1. Enter the disease, or companies, or heart failure. List only	plications that caused	the death. Do not e					-	Approximata Interval Between	-
edical eminer	Immediata Causa (Final disease or condition resulting in death)	a	Due to (or as a cons	equence of):	eart D	1 'કરવ દર			Months	
the burishmark  the burishmark  dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c	Due to (or as a cons							
d by the attending physicie letached for use as the bur letached for use as the bur Physician/Medical	resulting in death) Last	d	Due to (or as a conse	equence of):						
the atte	Part II. Other significant conditions of	ontributing to death bu	ut not resulting in the	underlying cause gi	ven in Part I.	23b. Did to	obacco use con	tribute to	the cause of death?	-
detached for use as Y Physician/Me				January my decision y		101	4.0		pebly 4 Unknown	
page 2 should be det Completed by P						24a. Was a perfor		ava	ara autopsy findings ailable prior to mpletion of cause death?	-
om Com						1 U Y	as 20 No	10	Yas 2□No	
director, page 2	25. Was casa referred to medical axaminer?				26. Place of Dea	th (Check only or				
00	1 □ Yes 210 No	Hospital: 1 Inpatie		BIR 3LI DON	her: 4 Nursing H	ome 58 Resid	ence 6 Othe	or (Specify	y)	
Uner th	27. Manner of Death  Netural 5 Pending	28a. Data of Injui (Month, Day	y Year) 28b. Tima Injury	Wo		28d. Dascriba h	ow injury occurre	ed		
To the Funeral Director: After this completely filled in by the funeral of Medical Certification: To	2 \rightarrow \text{Accident} invastigation 3 \rightarrow \text{Suicide} & 6 \rightarrow \text{Could not by detarmined} 4 \rightarrow \text{Hornicide}	]Yas 2□No	28t. Location (S City or Tow	itreet and Numbern, State)	er or Rura	il Routa Number,	-			
pletely filled edical C		ysician: To the best of niner: On the basis of and manner sta	axamination and/or i							-
Within 24 hours To the Funeral D completely filled i	29b. Signature and titla of confiler	1		29c. Licen	se number	- 2	29d. Data signed	(Month,	Day, Year)	_
	1/1	, m	)	D	(2447		My 2	7 19	99	
	30. Name and address of season who	completed cause of de	eath (Item 23a) (Type		ane	Caturs	ile N	1007 1	an	
State Registrar	31. Data filed (Month, Day, Year) MAY 2 8 19	32. Registre	ar's Signature	Some	,					



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 24, 1999 Ida Gutknecht Worden 12:15 PM May /Medical 4a Fecility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Corsica Hills Center Genesis Eldercare Centreville Queen Annes If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Yeer 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 10 M 2 F Days 579-12-0257 88 Director APR 14, 1911 Germany Usual Residence of Decedent the Marylend 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Modical Examiner must be notified at 1 Yes 2 No Director Oconee Salem 10e. Street end Number 10f. Zip Code 10c. Citizen of What Country? 1 Hawser Court 29676 USA Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Status Bleck, White, etc. permit. Pages 1 end 2 should be filed within 72 hours effer to Department of Heelih end Mental Hygiene. Important: If itsm 27 is marked other than "natural", or item eny injury or other traumatic event, the Magical Exercisms. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Household Furniture Elementary/Secondary (0-12) College (1-4or 5+) Owner/Office Manager Moving Business 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Gustav Gutknecht Bertha Petrich 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) John E. Worden, Jr./Son Hawser Court Salem, SC 29676 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 In Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 5/25/99 Baltimore, MD 21. Signetura of Funeral Service Lice 22. Name and Address of Facility
Cremation Society of MD, Inc. show A. Edward A. Edward A. Preorchik 299 Frederick Road Bal 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. 299 Frederick Road Baltimore, MD 21228 Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel heart disease disease or condition resulting in death) **Examiner** Examiner physicien end s the buriel-transit Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as a consequenca of): Physician/Medical Due to (or es e consequence of): Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 3 Probably 4 Minknown 1 Yss 2 No milinar by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 ☐ Yes 2 ☐ NO 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: effer deeth. Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Surviving Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 Anatural 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 29a. Certifier 1 cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. Medical (Check only one) 2 Medical Examinar: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number D32036 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 2/08 D. Dorah Drive Cherker, MJ 2/6/9 more 32. Registra Signature 31. Date filed (Month, Day, Year) State Registrar



	Certificate of Death  1. Decedent's Name (First, Middle, Last)	2. Dete of De		3. Time of Death	
sician edical	Leah G. Warehime	Month May 25	Day Yea 1999	9:30 AM	
miner		own, or Location of Death	4c. County of De		
		ltimore		/A	
ral tor	5. Social Security Number  212-05-2322  G. Sex  1 M 2 X T Age (In yrs. lest birthday)  83 Yrs.    If Under 1 Year   If Under 1 Year   Hours	Min. (Month, Da		Birthplace (State or Foreign Country) aryland	
	10a. Stele 10b. County 10c. City, Town or Location			10d. Inside City Limits	
ctor	Maryland N/A Baltimore			1)XO(Yes 2 □ No	
Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What		
	3531 Buena Vista Avenue 21213  11. Meritel Stetus 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic On			SA nerican Indian,	
by Funeral	11. Meritel Stetus  12. Was Decedent Ever in U,S. Armed Forces?  1 Never Merried 2 Merried  2 Wildowed 4 Divorced  12. Was Decedent of Hispanic Or if Yes, specify Cuban, Mexican Hyes, Give Year or Detes:	n, Puerto Rican, etc.)	Black, WI		
ted	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during mos	et of undring	16b. Kind of Busines	ss/Industry	
Completed	(Specify only highest grade completed)  Elementery/Secondery (0-12)  College (1-4or 5+)  Homemaker	a or working	In Own	Цото	
		er's Neme (First, Middle,		поше	
To Be	William Walter Jones	lizabeth Sh	effer		
	19e. Informent's Neme/Reletionship (Type, Print)  19b. Mailing Address (Street and Numb	er or Rural Route Numb	er, City or Town, State	, Zip Code) 21211	
	Robert Warehime Son 3533 Buena Vist				
	XX Burial 2 Cremetion 3 Removel from State cemetery, cremetory or other place)	Dete	20c. Location - City		
Į,	4 Donetion 5 Other (Specify) Moreland Memorial Park  21. Signature of Puneral Service Licensee 22. Name and Address of Facilia Burgee-Henss-Service Service Licensee 3631 Falls Road			, Maryland	
Examiner	Immediate Cause (Finel dishards or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.  Immediate Cause (Finel disease or condition resulting in death)  Due to (or as a consequence of):	cardiac or respiretory e	rrest,	Approximate Interval Between Onset and Death	
Ballon	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):				
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Completed			an autopsy 24lomed?	b. Were autopsy findings available prior to completion of cause of death?	
Cou		10	Yes 2DNo	1□ Yes I No	
89	examiner? Hospital: Other	e of Death (Check only o			
tion: To	1   Yes 2 No		dence 6 ☐Other (S) how injury occurred	pecify)	
Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)	28f. Location ( City or To	281. Location (Street and Number or Rural Route Number, City or Town, State)		
ertific		nd place, end due to the	cause(s) end manner date end place, and d	as stated. lue to the cause(s)	
	29a. Certifier  Chart and Control of the best of my knowledge, deeth occurred et the time, date er  2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, dee and manner steted.	oth occurred at the time,			
Medical Certific	2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, dee and manner steted.  29b. Signature and title of certifier  29c. License number		29d. Date signed (Mo	onth, Day, Year)	
edicai	2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, dee and manner steted.		29d. Date signed (Mc		
edical	2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, dee and manner steted.  29b. Signature and title of certifier  29c. License number	76	5-26.		

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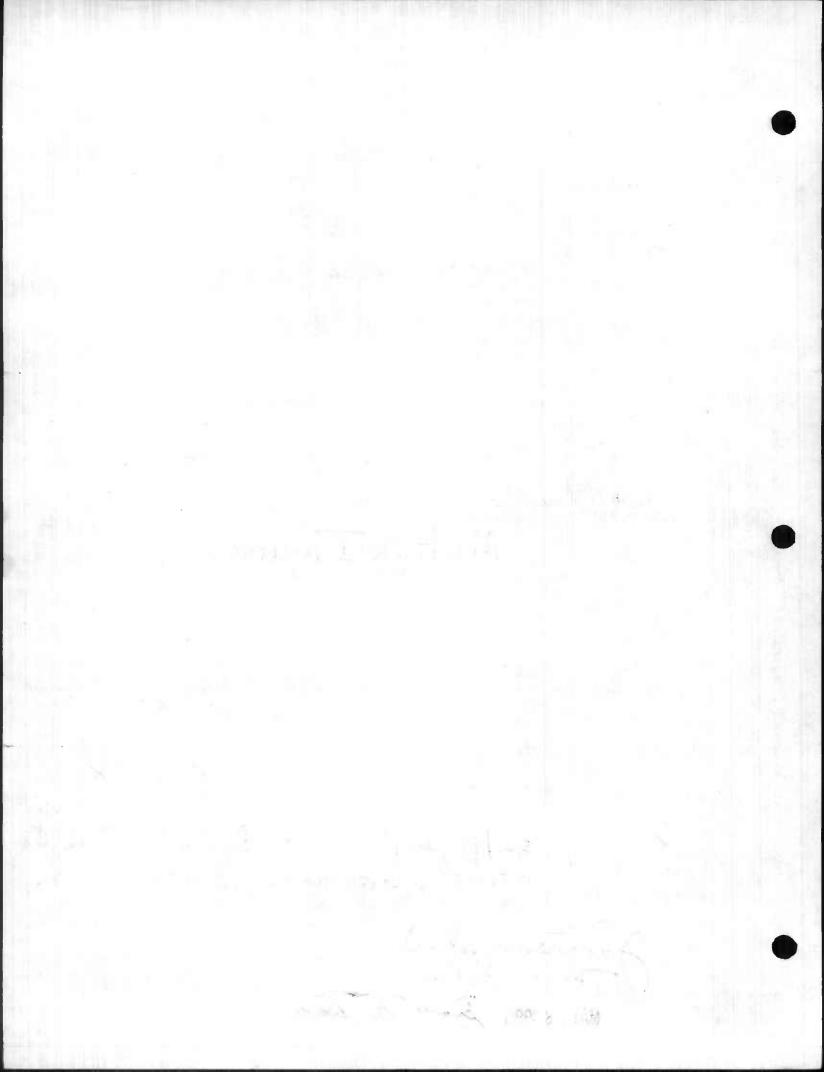
Committee Constitution

WAYNE ASP	S. WILLER			Maryland		rtment of tificate of		and M		Reg. No.	99 1	7163
Physician /Medical	1. Decedent's Name Wayne S.	Weller,							2. Date of D Month MAY	Dey	Year 1999	3. Tima of Death
Examiner	4e Facility Neme (If n 837 GLE		e street and num	nber)			4b. City, To Baltim		ocation of Dea		County of Death	
Funeral Director	5. Social Security Nur 217 04 9634	1	G., .G-	7. Age (In yrs. la: 17	st birthday) Yrs.	If Under 1 Year Months Days	r If Under		8. Date of B (Month, D January	irth Year) 7 11, 1	9. Birth Cou 1982 Towso	place (State or Foreign intry) Maryland
show show idet		10b. County  Baltimore			Town or Lo							10d. Inside City Limits 1 ☐ Yas 2 ☐ No
or 28e-f	10e. Street and Numb	per		Darch	moire Co	10f. Zip Code					en of What Cou	1
after death with the Maryle or Items 22s or 23s-1 sho smicer must be notified at Y Funeral Director	79 Roger Val.	ley Court	12. Wes Dece	dent Ever in U,S	. 13. V	21234 Ves Decedent of Yes, specify Cul	Hispanic Ori	gin? (Sp	ecify Yes or N Rican, etc.)	USA 10- 1	4. Race - Ameri Black, White	
0 5 4 6	3 ☐ Widowed 4		1 Yes If Yes, Give Year or De	B		☐ Yes 2⊠ No					Specify: Whi	
ed within 72 hours at typiens. we than "natural, or it, the Medical Exam Completed by I	(Specify Elementary/Second	5. Decedent's Education only highest gradery (0-12)	ducation ade completed) College (1-	-4or 5+)	(Give I	ent's Usuel Occu kind of work done DO NOT use retin	e during most	t of work	ing		nd of Business/Ir	ndustry
日本	17. Father's Neme (Fi				Studer	IL .	18. Mothe		e (First, Middl	-	Sumame)	
and 2 should be selfth and Mental visit and Mental visit is marked on traumatic ever traumatic every To B	19e. Informent's Nem Verma Scheel	ne/Relationship (				g Address (Streeter Valley	et end Numbe	er or Run	al Route Num			p Code)
Pages 1 en hent of Heat ret: if New 2 sry or other	20e. Method of Dispos 1 Dauriel 2 Dauriel 5	sition Cremelion 3	Removel from S	Stele	ce of Disponentery, cren	sition (Name of netory or other planetery Ma	ace)	1	Date	20c. Loc	cation - City or T	
parmit. Departr Imports any inju	21. Signature of Fund 23e. Part1. Enter the	ex des	D ato	Direck	122 123 74	Name and Addi ASSAM Fun 101 Belair	ess of Facilities and Ho Road B	me, I altim	ore, Mar	yland		
Physician /Medical Examiner	Immediate Cause (Fi disease or condition resulting in death)	feilure. List only	e.	Due to (or a	tp	1	-		ies	errest,		interval Between Onset and Death
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at the death certificate the death certificate the attending physician of the standard for use as the Physician/Medic.	Pert II. Other significa	ant conditions of	d	ath but not result	ing In the ur	nderfying cause g	jiven in Pert I	l.	23b. Die	d tobacco	use contribute	to the cause of death?
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ysicien: The law s certificate has director, page 2.	25. Wes case referred	d to medical					26. Place	of Deat	1) h (Check only	•	□No 1	Yes 2 No
수 등을 누	1 Yes 2 Ne 27. Menner of Death	0		-	8b. Tima of	3 DOA O	-	ursing Ho	ome 5 ☐ Res	The state of the s	Other (Spec	(v) SCENE
tal or Attending Physics attending Physics attending Physics attending the funeral led in by the funeral Certification: 1	1 Detural 2 Accident 3 Suicide 4 Homicide	5 Pending investigation 6 Could not be determined	5/21 e 28e. Pieca	199 :	Injury		Yes 2 🗹	No 2d	28f. Location City or T	(Street and own) State)	d Number or Ru	mether velocity rail Route Number, MCL
To the Hospital or J within 24 hours after To the Funeral Dire completely filled in E Medical Certi	29e. Certifier 1 (Check only 2 one)	Certifying Ph	ysicien: To the I niner: On the ba end menn	sls of examinetic	edge, death on and/or inv	occurred at the restigation, in my	time, date en opinion, dee	d place, th occur	and due to the red et the time	e cause(s) e, date end	and menner as plece, and due	stated. to the cause(s)
To the To the comp	29b. Signature and tit	6 of certifier	tanen	M.	6.		ose number			29d. Date MAY	e signed (Month 22, 199	

State Registrar

DHMH 16 Rev 6/95

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death Day Month Yaai **Physician** 6:50 pm 05 1999 14LIAM YEAGER 25 /Medical 4b. City, Town, or Location of Daath 4c. County of Death Facility Nama (If not institution, giva street and number) Examiner Baltimore
If Undar 24 Hrs. 8. Deta of Birth
Mours Min. (Month, Day, Year) Johns Hopkins Bayview Medical Center
5. Social Sacurity Number 6. Sax 7. Age (In yrs. last birthday) # Undar 1 Yaar Baltimore Birthplace (State or Foreign Country) **Funeral** Days Months 1⊠M 2□ F Yrs. 215-14-5974 75 Director June 23 1923 Usuet Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. insida City Limits x 28a-f show a notified at 1 ☐ Yas 2 ☑ No Director MD Baltimore Dundalk 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? with "natural", or items 23s or adical Examiner must be 7022 Dunbar Rd 21222 USA Funeral Pages 1 and 2 should be filed within 72 hours after deeth nent of Health end Mental Hygiene. 12. Was Decedent Evar in U,S. Armed Forcas? Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Raca - Amarican Indian, 11. Maritai Status Btack, Whita, atc. 1 Naver Marriad 2 Married ☐ Yes 2 No Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: þ 3 Widowed 4 □ Divorced White shours to and Mental Hygiene.

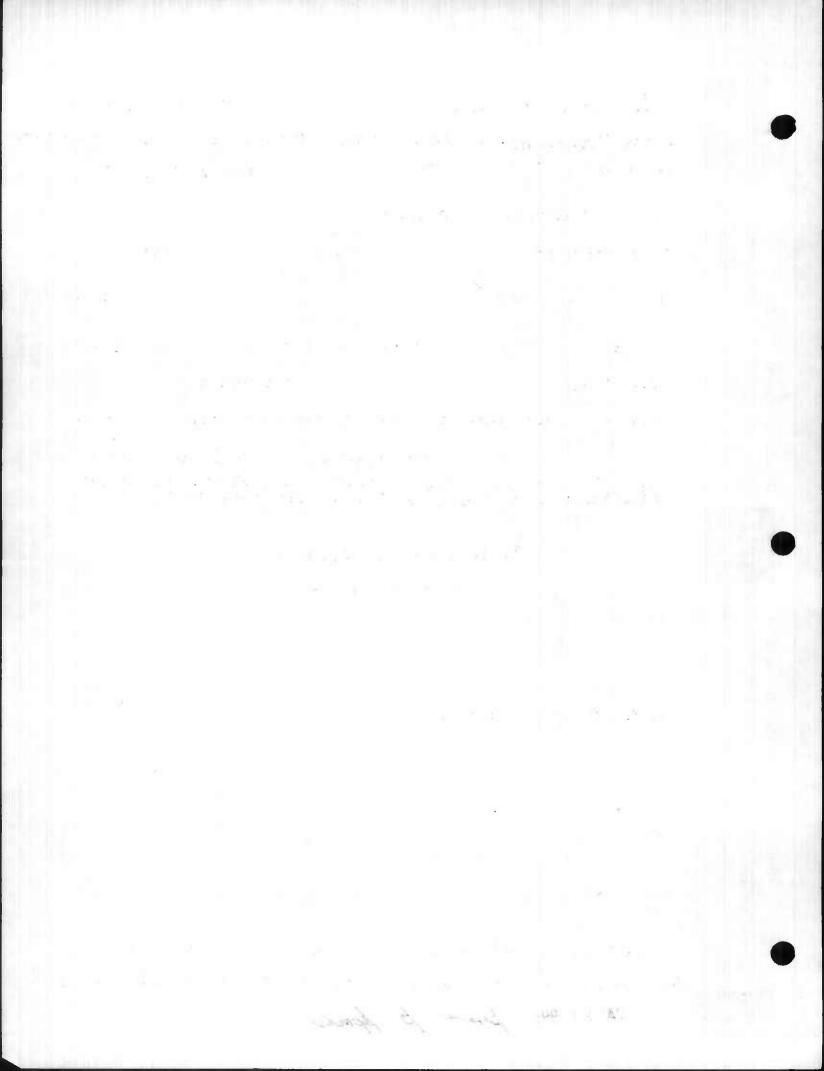
a marked other than "natural" Completed 16a. Decedant's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada completed) Elamantary/Secondary (0-12) Coltege (1-4or 5+) Metalergical Clerk Beth - Steel 12 18. Mother's Nama (First, Middla, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Be Harry Yeager Ruth LeBrun 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Retationship (Type, Print) .00 Health em 27 i Robin S. Taylor /daughter 3331 Belsford Ct Baltimore, MD 21222 other 20b. Place of Disposition (Nama of cematary, cramatory or other place) May 26 20a. Mathod of Disposition 20c. Location - Cify or Town, Stata 1 ☐ Burial 2 ☑ Cramation 3 ☐ Ramoval from Stata 5 = 1999 4 ☐ Donation 5 ☐ Othar (Specify) Metro Crematory Catonsville, MD 21. Signatura of Funeral Sarvice Licensea 22. Nama and Addrass of Facility
Connelly Funeral Home of Dundalk 23a. Parfl. Entar tha disease or complications that caused the death. On not antar tha mode of dying, such as cardiac or respiratory arrast, shock, or haart failure. It only one cause on each line. 7110 Sollers Point Rd 21222 tntarvat Between Onset and Death **Physician** /Medical Immadiata Causa (Finat · Cerebrovascular Accident disaasa or condition rasulting in daath) Examiner Dua to (or as a consequence of) Examiner arotid stenosis requires that the death certificate be executed physician and the burial-transit Sequentielly list conditions, if any, laading to Immadiata causa. Entar Undarlying Couse (Diseese or Injury that initiated avants resulting in death) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Dua to (or as a consequanca of): 98 080 Po Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3₩ Probably 4 Unknown 1 ☐ Yes 2 ☐ No Seizure. pneumonia þ 24b. Wera autopsy findings available prior to complation of cause of death? 24a. Wes an eutopsy performad? Completed page 2 s certificate has 1 Yas 200No 1 Yas 2 No or Attanding Physician: 25. Was casa referred to medical axaminar? Be 26. Placa of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) 10 1 Yas 2 No 1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Mannar of Death 28b. Tima of 28d. Dascribe how Injury occurred Certification: 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 5 Panding invastigation 1 XNaturat 1 ☐ Yas 2 ☐ No death. 2 Accidant after death Director: 3 Sulcide 6 Could not be determined 28a. Ptace of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Route Number, City or Town, Stata) filled in by 4 Homicida 24 hours a Hospital edicai 29a. Cartifian 1🔂 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as statad. completely 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and titla of certifiar 29c. License number 29d. Date signed (Month, Day, Year) ackson, no LSa 30. Nama and address of person who completed cause of deeth (Item 23e) (Type, Print) Johns Hopkins Bayview Medical Center, 4940 Eastern Avenue; Baltimore 21224 Jackson, Allesa 31. Data filed (Month, Day, Yaar)

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State Registrar

MAY 2 8 1999

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

AMEND IYEM#	8 PER F.H. G771 5-28	3-99 J.A.	of Maryland /	Certifica:			i Mental H	Reg. No.	99	7165
Physician	1. Decedent's Name (First, Mide						2. Date of D Month	Dev	Year	3. Time of Death
/Medical	Elizabeth bolores					15 ON Town	May or Location of Dea	22,	1999	12:00 PM
Examiner	4a Facility Name (If not institution 8504 Marblehead Ri	-	m <i>ber)</i>			Lutherv:	ille		Sounty of Death Baltimore	co.
Funeral Director	5. Social Security Number 219–22–8616	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs. last b	Yrs. If Under Months	Days	If Under 24 H Hours Mi		irth 1928 lay. Year) 1, <del>199</del> 9	9. Birthy Balti	place (State or Foreign more, Maryland
pue &	Usual Residence of Decedent  10a. Stete 10b. Count	у	10c. City, To	wn or Location	-				11	IOd. Inside City Limits
Mary H ah	Maryland Balt	imore Co.	Luth	erville						1 ☐ Yes 2 ☑ No
y 28s	10e. Sfreet and Number		2001		Code			10g. Citiz	en of What Cour	ntry?
th wit	8504 Marblehead R	oad			21093			United	States o	of America
21215-0020 d within 72 hours after death with the Manyland jiene, rhan 'natural', or items 23a or 28a-f ahow the Madrial Engineer must be notified at completed by Funeral Director		Armed Fo	2 No	If Yes, specify Cu			(Specify Yes or Nerto Rican, etc.)	100	I. Race - Americ Black, White, Specify: Whi	etc.
72 hours	15. Decede	nt's Education est grade completed)	16	a. Decedent's Usu	el Occup	ation	ndrina	16b. Kin	d of Business/In	dustry
1 21215-0 ed within 72 ho ygiene. For than "neturing, the Madical and Completed	Elementary/Secondary (0-12)	College (	1-4or 5+)	(Give kind of work done during most of life. DO NOT use retired)			OIKIII			
255 0		n/a		Hom	e Make		ama (Cina) A Sidali	1	Own Home	
	17. Father's Name (First, Middle Frederick George						eme <i>(Firs</i> t, <i>Middl</i> Lores Lewi:		umame)	
should by merked merked american	19a. Informent's Name/Reletion		19	b. Mailing Addres	s (Street				Town, State, Zir.	Code)
C 10 00 b	Mr. Robert G. Zel	ler(Son)		7 Llewelly			sford, Pa.			
OTC 18 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	20a. Method of Disposition		20b. Piece cemer	of Disposition (Ne	me of other place	(e)	Dete	20c. Loc	ation - City or To	own, State
Page Page nent it ury or	1 X Buriel 2 Cremation 4 Donation 5 Other (		21616	r Memorial			5/26/1999	Bel A	ir, Maryl	and
Baltimore, permit, Pages 1 a Department of Hei Important if hem any injury or othe once.	21. Signature of Funeral Service	Licenson	//	22. Neme a	nd Addres		ick Towson 050 York R			
68760, fileste be executed fileste be executed fileste be executed as the buriel-transit edical Examiner edical Examiner	Cause (Disease or injury that initiated events resulting In death) Lest	a. Lo	Due to (or as a	a consequence of)	21/	hyThe D.	heme	Ba	ma/	Intervel Between Onset and Death
.O. BOX the death cert by the attending sached for use a thysiclan/M	Part II. Other significant condit	d	eath but not resulting	in the underlying	cause giv	en in Part I.		tobacco u		o the cause of death?
ecords,  we requires th  se been signed  2 should be d  pleted by								s an autops formed?	80	ere autopsy tindings ailable prior to impletion of cause death?
= F # a 0							1	Yes 20	LNO 11	☐Yes 2☐ No
Of Vital I Physician: The this certificate ral director, page ral dire	25. Was case referred to medic	Hospital:			Oth	OF:	eeth (Check only			
는 하는 한 다	1 ☐Yes 2 ☐ No 27. Manner of Death	28e. Date	Inpatient 2 ER/C		28c. Injun	4 LI Nursing	Home 5 PAes 28d. Describe			(4)
Division of the or Attending P is after death.  at Director: After the of in by the funeral Certification:	1 Pretural 5 Pendi 2 Accident invest 3 Suicide 6 Could 4 Homicide deter	ng (Moni igation not be nined 28e. Place	th, Day Year) of Injury - At home, ing, etc. (Specify)	М	10	k? Yes 2 □ No	28f. Location			al Route Number,
Hospi 14 hou Funer tely fill	29a. Certifier 1 Certifyl (Check only one) 2 Medica	ng Physician: To the Examiner: On the be	best of my knowledg asis of examination s ner steted.	ge, deeth occurred nd/or investigation	at the tim	ne, dete and pla pinion, deeth oc	ce, end due to the	cause(s) a	and menner as a place, and due t	stated. o the cause(s)
To the within 2 To the comple	29b. Signature and title of certific		Done	celle	c. License	9 number 5 - 093	383	29d. Date	signed (Month,	Day, Year) R. 1999
	30. Name and address of person  30. Name and address of person  31. Date tiled (Month, Dey, Year	F.O'	) onne	(Type, Print)	11	1821	mleTi	4,11	MI	21210
State Registrar	MAY 2 8 199		egistrar's Signature	Spark						

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Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** 1239 JAMES DOUGLAS ALLEN MAY 08, /Medical 4b. City, Town, or Location of Deeth 4e Facility Nema (If not Institution, giva street and number) 4c. County of Death Examiner HATBORO UPPER MAPLBORD PRINCE GEORGES 2903 PLACE If Undar 1 Yaar | If Undar 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Sacurity Number Birthplece (State or Foreign Country) 7. Aga (In yrs. last birthday). **Funeral** 1 € M 2 □ F Deys 244-68-6686 54 Yrs JANUARY 24, 1945 Director Usual Rasidence of Dacadent with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits r than "natural", or itema 23s or 28s-f show the Medical Examiner must be notified at 1 Yas 2 □ No Director PRINCE GEORGE'S Maryland UPPER MARLBORO 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 2903 HATBORO PLACE 20772 USA Funeral death permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If tem 27 is marked other than any Injury or other traumments. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1X Yes 2 No Army If Yes, Give Year or Dates: 1971-1993 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: BLACK þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Retired Elementary/Secondary (0-12) College (1-4or 5+) US GOVT. (Military) Quartermaster Corps Officer 6+ 18. Mother's Neme (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) Dorothy Allen Unknown 19a. Informent's Name/Reletionship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Almenta G. Bell/ Cousin 8817 Stonehaven Rd. Randallstown, MD 21133 20b. Place of Disposition (Name of cametery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Burial 2 Crametion 3 Ramoval from State Arlington National Cem. 5-20-99 4 ☐ Donetion 5 ☐ Other (Specify) Arlington, Virginia 22. Name end Address of Fecility Marshall's Funeral Home of MD 4308 Suitland Rd. Suitland, Maryland 20746 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one ceuse on each line. Approximete Interval Between Onset and Deeth **Physician** Immediete Ceuse (Finel disease or condition resulting in deeth) /Medical . HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Examiner Due to (or as a consequence of): Examiner attending physician end for use as the bunal-transit certificate be executed Sequentially list conditions, if eny, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequenca of): Box 68760. Physician/Medical Due to (or es e consequence of): P.0. Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? the the 1 Yes 2 No 3 Probably 4 Unknown DIABETES MELLITUS by 8 24b. Were autopsy findings evelleble prior to completion of causa of death? 24a. Was an autopsy performed? Completed 990 1 Yes 2 N No 1 Yes 2 No certificate Division of Vital 25. Was case referred to medical exeminer?

1 XYes 2 No Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Inpatient 2 ER/Outpetient 3 DOA this uneral 27. Manner of Deeth 28d. Describe how injury occurred 28e. Dete of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No death. after death Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicida 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled is 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the ceuse(s) end manner es stated.

Medical Examiner: On the bests of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date and plece, and due to the cause(s) and manner estated. edicai 29e. Certifier (Check only one)

29c. License number

DME

death (Item 23a) (Type, Print)

3001

ted cause of

MO 32. Registrar's Signeture 29d. Deta signed (Month, Day, Year)

MAY 10, 1999

DRIVE CHEVERLY, MARYLAND 20785

State Registrar

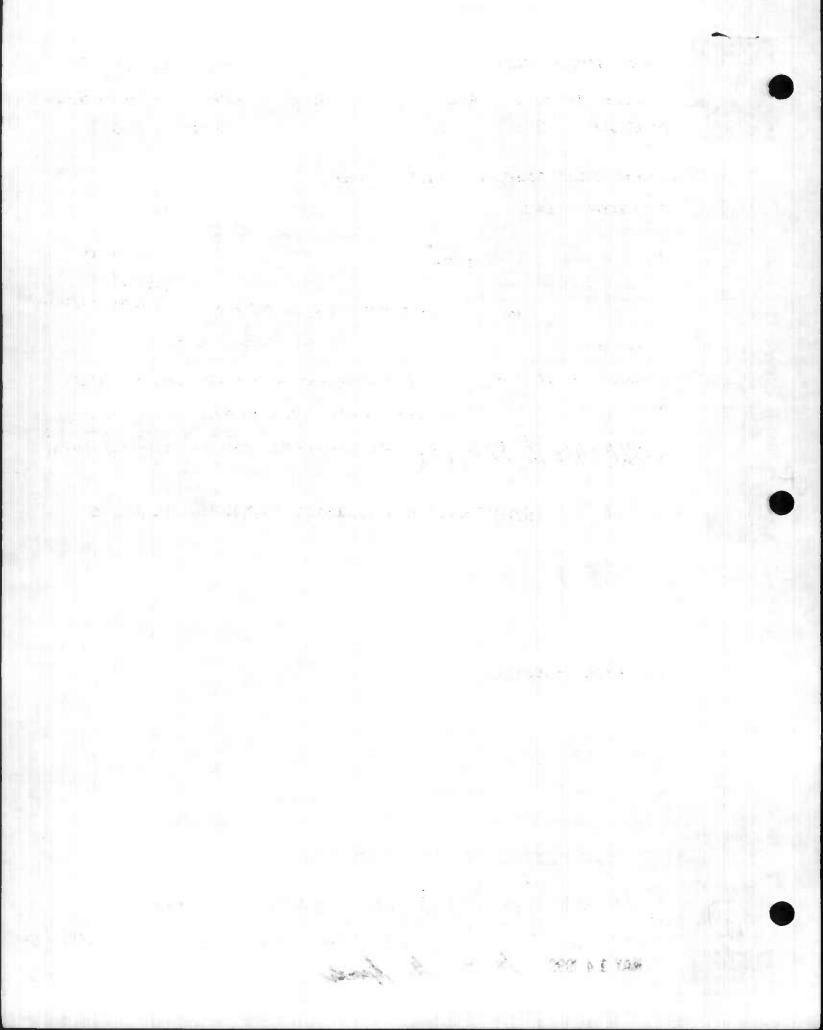
29b. Signature

MARIO

30. Name and eddress of person who co

GOI

**DHMH 16 Rev 6/95** 



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month May 9, **Physician** 1999 1:05 pm Judith Amos /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 846 San Mateo Trail Lusby Calvert If Under 24 Hrs. If Under 1 Year 5. Sociel Security Number 7. Age (In vrs. last birthdev) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year, **Funeral** Months 1 ☐ M 2 X F Deys Hours 58 Yrs. 217-36-6130 1940 Washington, DC Director Usual Residence of Decedent the Maryland 10a. Stata 10c. City, Town or Location 10d. Insida City Limite permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Haalth and Mental Hyglene. Important: If Item 27 is marked other than "naturel; or Items 23a or 28a-f show any Injury or other traumatic event, the Madical Examines must be nother as 10b. County 1 ☐ Yas 2 No Directo Maryland Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 846 San Mateo Trail 20657 U.S.A. Funeral Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Rece - American Indien, 12. Was Decadent Ever in U,S. 11. Meritel Stetus Black, Whita, etc. Armed Forcas 1 Never Merried 2 Married 1 ☐ Yes 2 ☒ No Il Yes, Give altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced White Yaar or Datas: Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Spacify only highast grade complated) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Merchandizing Supervisor Private/Retail 10 17. Father's Neme (First, Middle, Last) 18. Mothar's Neme (First, Middle, Meiden Sumeme) Be William Watson Helene Bost 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Sherry E. Ehrlich - Daughter 322 Fairmont Drive, Edgewater, Maryland 21037 20b. Piece of Disposition (Nema of 20a. Method of Disposition 20c. Location - City or Town, Stete cematery, crametory or other plece) 1 XBurlel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Fort Lincoln Cemetery 05/12/99 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Neme end Address of Fecility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** 40-11AL cancer colon /Medical tmmediete Ceuse (Finel disaesa or condition resulting in deeth) Examiner Due to (or es e consequence ol) Examiner The law requires that the death certificata be asscuted physician and s tha bunal-transit Sequentielly tist conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence oi): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) for usa as 88 been signed by the s Pert It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yee 2 No 3 Probably 4 Unknown p 24b. Ware autopsy findings aveileble prior to completion of cause of death? Completed 24e. Wes an autopsy is certificate has t director, page 2 s 1 ☐ Yes 2 ☐ No Attending Physician: Be 25. Wes case referred to medical examinar? 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 ☐ Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA this funaral 28e. Dete of Injury (Month, Dey Year) 27. Megner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: \*\* Hospital or An.
\*\* hours after death.
\*\* I Director: After ">\*\* by the fur Aftar 1 Neturet 5 Pending Investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident the Funeral Director of the Fu 3 Suicide 6 Could not be 28e. Ptece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide 10 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and pleca, end due to the cause(s) and menner stated. 29a. Certifier To the Hosp within 24 hos To the Fune completely fi Medical 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifier 29c. License number May 10, 1999 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Bruce Silver, M.D., 110 Hospital Road, S-110, Prince Frederick, MD 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State MAY 1 1 1999 Registrar

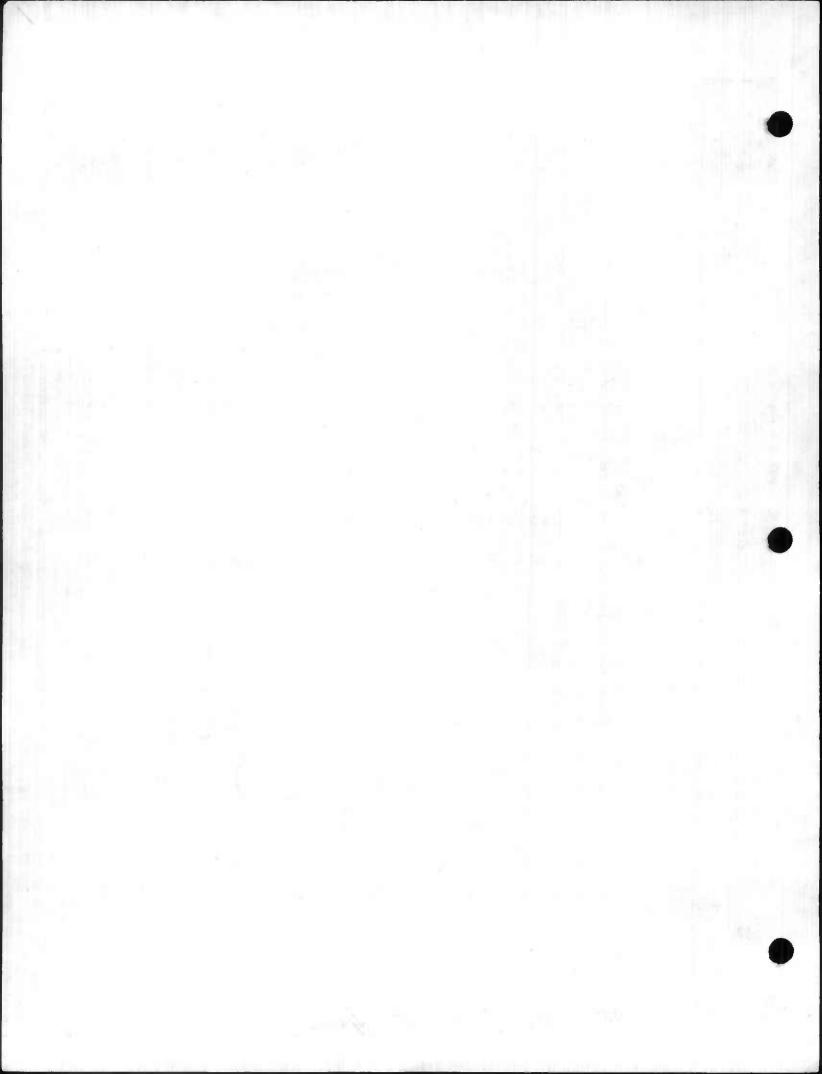
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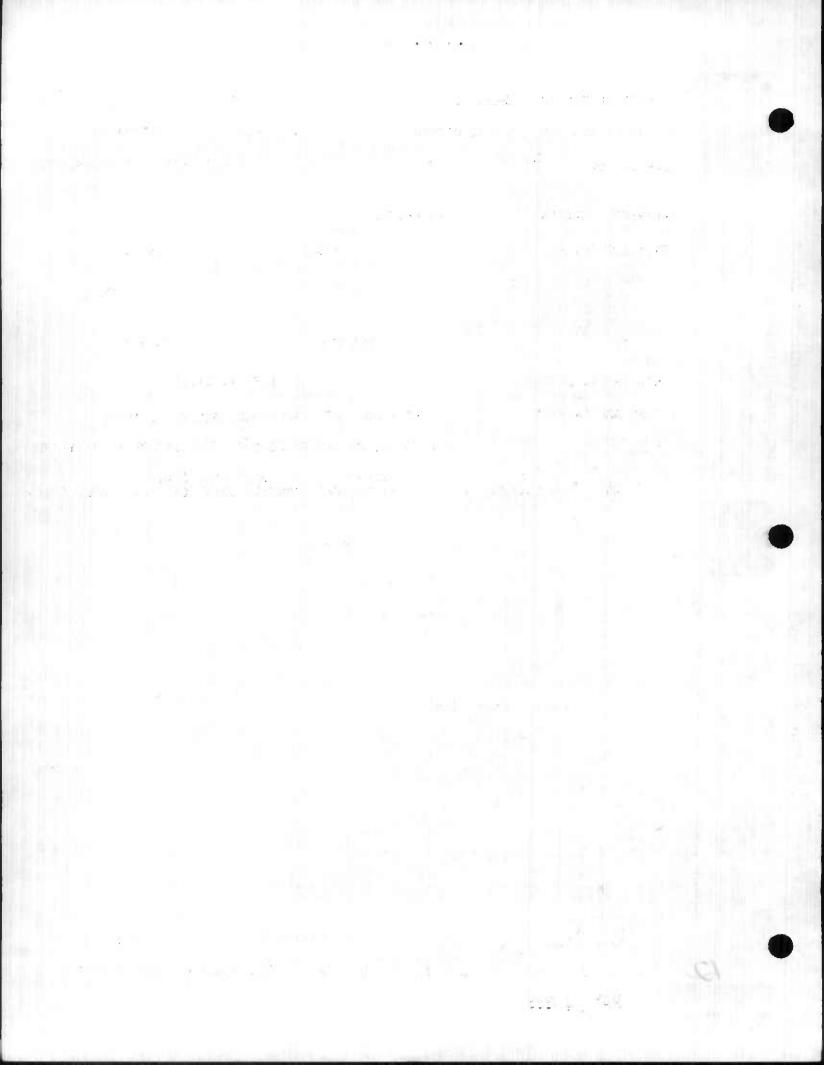
	Certificate of Death		Reg. No.	17168
Physicia	1. Decedent's Name (First, Middle, Last)	2. Date of Dea Month		3. Time of Death
/Medica	riccollas Ducter Albaugh	.5		19 / 19m
Examine	4a Facility Name (If not institution, give street and number)  Carroll County General Hospital  Westmi:	nster	Ca	rroll
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Annual Months Deys Hours Min.	8. Date of Birth (Month, Day June 14	, Year) 932	Birthplace (State or Foreign Country) Maryland
De .	Usual Residence of Decedent  10a. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits
with the Maryland a or 28a-f show be notified at				1 ☐ Yes 21 No
r 284	Maryland Carroll Union Bridge  100. Street and Number  101. Zip Code		10g. Citizen of Wh	at Country?
th with		1	U	.S.A.
5-0020 72 hours after death with the Maryland natural; or flame 23s or 28s-f show also Examiner must be notified at	11. Maritel Stetus 12. Was Decedent Ever in U,S. Armed Forcas? 1 Never Merried 2 Married 1 Never Merried 2 Nerried 1 Never Merried 1 Never Merried 2 Nerried 1 Never Merried 1 Never Merried 2 Nerried 1 Never Merried 1 Nev	pecify Yes or No- Pican, etc.)	14. Race - Black, Specify:	American Indian, White, etc.
15-002 n 72 hours "natural",	3 Wildowed 4 Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's Usual Occupation	1	16b. Kind of Busi	
215	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) farmer/rural mail carr	king		
Maryland 21215-0020 d 2 should be filled within 72 hours aff th and Mental Hygiene. The marked other than "patural", or traumatic event, the Medical Earn	farmer/rural mail carr		7 . 2	stal service
land lid be file ental Hyg	17. Father's Neme (First, Middle, Last)	ne (First Middle, 11us But	Maiden Sumame)	
should be and Mental or marked or umatic eve	Ira Albaugh  19a. Informent's Neme/Reletionship (Type, Print)  19b. Meiling Address (Street end Number or Ru			tate 7in Code)
			dge, MD	
Ore of H	20e. Method of Disposition  20b. Place of Disposition (Name of camelory, cremetory or other place)	Date 5/13/99	20c. Location - C	ity or Town, State
Baltime permit. Pag Department Important: H any injury o	21. Signard of Funeral Service Licensee 22. Name end Address of Fecility Ha	rtzler F	oneral H	ome
	23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each limit.		_	Approximete Interval Between
Physician /Medical Examiner	tmmediate Cause (Final disease or condition resulting in death)  LNTRACEREBRIAL HEMOR  Due to (or as a consequence of):	RHAGE		Onset and Death
5876( icata be physicia s the bur	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury thet initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  d.  Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.	pa v	isepse	YEARS
deati deati	Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Dld t	obacco use contr	ibute to the cause of death?
res that the designed by the a	DIRBETES MELLITUS	101	res 2 No 3	B Probably 4 Unknown
of Vital Records, P.O. Box ( Physician: The law requires that the death certificate has been signed by the attending ral director, page 2 should be detached for use a		24e. Was perfor	an autopsy med?	24b. Were autopsy findings available prior to completion of cause of death?
I Rec		1 D Y	es 2 No	1 Yes 2 No
r Vital I	25. Wes case referred to medical examiner?	th (Check only o	ne)	
Of Vita Physician: this certific ral director.			lence 6 Other	
Division of within 24 hours after death. To the Funeral Director: After this complataly filled in by the funeral director.	1 Salvetural 5 Pending (Month, Day Year) Injury Work? 2 Accident Investigation 3 Suicide 6 Could not be		now injury occurre	or Rural Route Number,
Div.		City or Tow	m, State)	
Hos 24 ho Fund lataly f	29a. Certifier (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date end place countries to make the control of my knowledge, death occurred at the time, date end place countries to make the countries of my knowledge, death occurred at the time, date end place countries of my knowledge, death occurred at the time, date end place countries of my knowledge, death occurred at the time, date end place countries of my knowledge, death occurred at the time, date end place countries of my knowledge, death occurred at the time, date end place countries of my knowledge, death occurred at the time, date end place countries of my knowledge, death occurred at the time, date end place countries of my knowledge, death occurred at the time, date end place countries of my knowledge, death occurred at the time, date end place countries of my knowledge, death occurred at the time, date end place countries of my knowledge, death occurred at the time, date end place countries of my knowledge, death occurred at the time, date end place countries of my knowledge, death occurred at the time, date end place countries of my knowledge, death occurred at the time, date end place countries of my knowledge, death occurred at the time, date end place countries of my knowledge, death occurred at the time, date end place countries of my knowledge, death occurred at the time, date end place countries of my knowledge, death occurred at the time, date end place countries of my knowledge, death occurred at the time, date end place countries of my knowledge, death occurred at the time, date end place countries of my knowledge, death occurred at the time, date end place countries of my knowledge, death occurred at the time, date end place countries of my knowledge, death occurred at the time, date end place countries of my knowledge, death occurred at the time, date end place countries of my knowledge, death occurred at the time, date end place countries of my knowledge, death occurred at the tim	, and due to the or rred at the time, or	cause(s) and man date and place, an	ner as stated.  Indicate to the cause(s)
To the To the	29b. Signeture and title of certifier 29c. License number		29d. Dete signed	(Month, Day, Year)
	Mercit of rocco & MD Do 1663		5/10/	79
	30. Name and address of pecsah who completed cause of death (Item 23a) (Type, Print) GOGC WANNESTM, N  31. Date filed (Month, Day, Year) 32. Registrar's Signature	STER	TON R.	1157
State				
Registra	MAY 1 4 1999 Serva G. Sparks			

DHMH 16 Rev 6/95



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 1 7 1 9

						Ce	rtificat	e of	Death		R	eg. No.		
Dhualaia		1. Decedent's Nam	a (First, Middla, L	ast)							ete of Deat	h Day	Year	3. Tima of D
Physicia /Medica		WILLI	AM THOMA	S ARCHE	R. JR.					n	nay	1319	199	0700
Examine		4e Facility Neme (							4b. City, Town,	or Location	n of Deeth	4c. Count	y of Death	
		PENINSUL	A REGION	AL MEDIC	CAL CENT	TER .			SALIS	BURY		WIC	OMIC	)
Funeral		5. Sociel Security N	lumber 6.	Sex	7. Age (In yrs.	last birthday	Months	1 Year Deys		Hrs. 8. D	ate of Birth Month, Day,	Veer)	9. Births	plece (Stete or I
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28a-f show	V.	10a. Stete	10b. County			ty, Town or L							1	1 ☐ Yas 2
- 1	Director	DELAWARE		X	F	RANKFO		0.4-			1.4	0. 011	14.0 C	
20 20	급	10e. Street and Nu	mber				10f. Zip	Code			1	0g. Citizen of	What Coul	ntry r
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aft.	P	/6	15. Decedent's I			16e. Dece	dant's Usu	al Occup	petion	working		16b. Kind of B	usiness/In	dustry
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the H	Bec	17. Father's Neme	(First, Middle, Las	st)					18. Mother's I	Neme (Firs	st, Middla, M	Maiden Sumer	ne)	
lenta lic e	ToB	WILLIA	M T. ARC	HER					MA	RY V	. WAL	I.S		
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of Health and Mental Hygiene. I them 27 is marked other than it other traumatic event, the M		20a. Method of Dis				Ptece of Disp	osition (Nei	me of	v - 1	De	ete	20c. Location	- City or To	own, Stete
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Department Important: II any injury o pace.		21. Signature of Fu	noral Service Clo	nul	'		MELSO	N FU	ess of Fecility UNERAL S ER STREE				T ATTA	DE 100
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ath. r. Ather e funer	atio	1 Neturet 2 ☐ Accidant	5 Pending Investigati		n, Day 1 ear)	Injury	M		Yes 2 No					
Ilca Ilca		3 ☐ Suicide 4 ☐ Homicide	6 Could not datarmine	d 286. Place	of Injury - At h	oma, farm, s	Ireel, factor	y, office		28f. L	ocation (Si City or Town	treet end Num n, State)	ber or Rur	el Route Numb
E 74 A	edical	29e. Certifier (Check only one)	1 Cartifying F 2 Madical Exa											
e Funeral letaly filled	P		title of contifier				29	c. Licen:	se number		2	9d. Data sign	ed (Month,	Day, Year)
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within 24 hours To the Funeral completely filles	2	29b. Signature and	u Su	o completed cause	•	m 23e) (Type		K	-	2015	buny		99	01



## **Physician** /Medical **Examiner Funeral** Director the Maryland 28a-f ahov ortant: If item 27 is marked other than "naturel", or itema 23s or 28s-f sho injury or other traumatic evant, tra Madical Examiner must be notified at Director Herna 23a Funeral

other than "naturel", or

permit. Peges 1 and 2 should be fi Department of Heelth and Mental F Important: If Nem 27 is marked off any july or other traumatic evea sonse.

**Physician** 

Examiner

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certificate

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After

within 24 hours after deat To the Funeral Director: completely filled in by the

deeth.

the Hospital

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Completed

Be

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Medical Certification:

i or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

/Medical

Peges 1 and 2 should be filed within near of Health and Mentel Hyglene.

Raby Boy

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Completed

2

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 4b. City, Town, or Location of Beath Joseph Smothers Akens, Jr. 4a. Facility Nama (If not institution, give street and number) C en e I Voar I Undar 24 Hrs.

Pays Hours Min.
20 OSecha imore -ranklin Square Sax 14 M 2□ F 8. Data of Birth (Month, Day, Yea Birthpiaca (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) Hours 1 May 10c. City, Town or Location 10d. Inside City Limits Yes 2□No Harford Aberdeen 10f. Zip Coda 10g. Citizen of What Country? 535 S. Parke Street 21001 USA Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puerto Rican, etc.) 12. Was Decedent Ever In U,S. Armed Forcas? Race - Amarican Indian, Black, Whita, atc. 1□Yas 2 No

1 ☐ Yes 2 ☐ No If Yas, Giva Year or Datas: 1 Navar Merried 2 Married 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grada complated)

16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired)

16b. Kind of Business/Industry

N/A

Black

Specify:

Elamantary/Secondary (0-12) N/A 17. Fathar's Nama (First, Middla, Last)

N/A

10b. County

N/A

Usuai Rasidence of Decedant

10e. Street and Number

10a. Stata

Joseph Smothers Akens, Sr.

LaKisha Akens

18. Mothar'a Nama (First, Middla, Maiden Sumame)

19a. Informant's Name/Ralationship (Type, Print)

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code)

N/A

LaKisha Akens

535 S. Parke Street, Aberdeen, MD 21001 20b. Place of Disposition (Nama of cemetery, cramatory or other place)

20c. Location - City or Town, Stata

20a. Method of Disposition XXBurial 2 Cremation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify)

ST. James Cemetery

5/22/99 Havre de Grace, MD

21. Signature of Funaral Sarvice Licensea

22. Nama and Address of Fecility Beard Funeral Home

Collega (1-4or 5+)

552 Lewis Street, Havre de Grace, MD 21078 23a. Part1. Entar tha diseasa, or complications that caused tha death. Do not antar tha mode of dying, such es cardiec or respiratory errest, shock, or heart failure. List only one cause on each line.

N/A

Approximate Intarval Batween Onset and Death 1000

Immediata Causa (Final disease or condition rasuiting in death)

10am nioni

Examiner Sequantially list conditions, if any, leading to immadiata causa. Entar Underlying Cause (Disaase or Injury that initiated avants rasulting in death) Last Physician/Medical

Dua to (or as a consequence of): remature pture Dua to (or es a consequence of):

Part ii. Other significant condition	contributing to death but not	rasulting In tha undarlying	causa givan in Part

23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were sutopsy findings available prior to completion of cause of death?

1 ☐ Yas 2 ☐ No

25. Was casa rafarred to medical 1 Yas 2 No

1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA

No 26. Piaca of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidence 8 Othar (Specify)

27. Magnar of Death 1 Natural 2 Accident

3 Sulcida

4 Homicida

5 Panding Invastigation 6 Could not be datarmined

MAY 19 1333

28b. Tima of

28a. Place of injury - At homa, farm, straat, factory, office building, atc. (Specify)

28c. Injury at Work? 1 ☐ Yas 2 ☐ No 28d. Describe how Injury occurred

29a. Certifian

Certifying Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the causa(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and piace, and due to the causa(s) and manner stated.

29b. Signature and titla of certifiar

29c. Licansa number

29d. Date signed (Month, Day, Year)

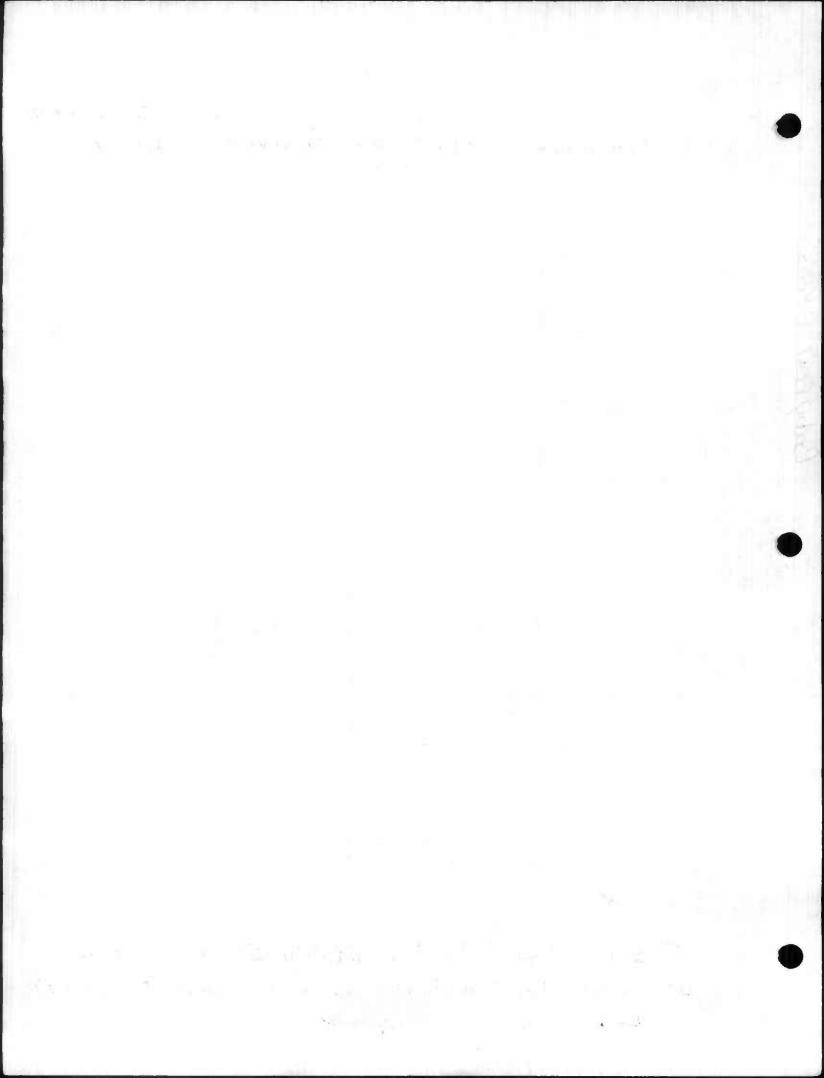
191759

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

30. Nama and addrass of person who completed causa of death (item 23a) (Type, Print)

9000 Franklin Square Drive Baltimore, MD. 21237 D. Sorah 31. Data filad (Month, Day, Year) 32. Registrar's Signatura

State Registrar



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					State of 1	viai yiai ic		tificate of			Rental Hyg	ig. No.		7171
			Decedent's Name (i	First, Middle, La	st)			100			2. Dete of Deat Month	h Dey	Yeer	3. Time of Death
-	Physician /Medical		Hilda	M	ary	Boni	figlio				May 2,		1001	10:20 pm
	Examiner		Fecility Neme (If no	ot Institution, giv	e street end numb	er)			4b. Cit	ly, Town, or Lo	cation of Deeth	4c. County	of Death	
			Doctor's	Commun	ity Hosp	ital				anham		Prin	ce Ge	orge's
	Funeral Director		Social Security Num 16-16-840	1	ex 7. □M 2X F	Age (In yrs. le	est birthday) Yrs.	If Under 1 Year Months Dey		Inder 24 Hrs. ours Min.	8. Date of Birth (Month, Dey, Oct. 6,			lece (Stete or Foreign try) sachusetts
٠	how		al Residence of De De State	ocedent 0b. County		10c. City	Town or Lo	cation					10	0d. Inside City Limits
	Mar Mar	Ma	aryland	Prince	George's	I	Bowie							1∭Yas 2□No
	or 28	106	. Street end Number	er				10f. Zip Code			1	0g. Citizen of V	Vhat Count	iry?
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020	72 hours efter deeth with the Maryland "natural", or ferma 23a or 28a-f show adical Examiner must be notified at	11.	Meritel Status 1 ☐ Naver Merried 3 🕅 Widowed 4 [		12. Wes Decede Armed Force 1 Yes 2 If Yes, Give Yeer or Dete	is? ∑ No		Wes Decedent of Yes, specify Cu I ☐ Yas 2 1 N		lc Origin? (Spe exican, Puerto ecify:	ecify Yes or No- Rican, etc.)		e - America ok, White, o	etc.
0-0	2 ho		. 15	Decedent's Ed	ducation		16e. Deced	lent's Usual Occ	upation			16b. Kind of Bu	siness/ind	lustry
21215-0020	s 1 and 2 should be filed within 72 hours e if Health and Mentel Hygiene. Item 27 is marked other than "natural", o other traumatic event, the Modical Even To Be Completed by	E	(Specify Elementery/Secondary 12	only highest gra ary (0-12)	College (1-4	or 5+)	life. L	kind of work don DO NOT use reti eamstre	red)	most of work	ng	Factor	rv Wo	rker
	be filed d other avent,		Fether's Neme (Fir	st, Middle, Last)					18.1	Mother's Neme	(First, Middle, I		/	
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Ž	end 2 saith er n 27 is	I.T	oseph Lar	ry Bonf	iglin -	Son	5805	42nd Av	enne	Hyat	tsville,	MD 20	0781	
re,	of Health I Nem 27 r other tr		. Method of Dispos		16110	20h Pk	ace of Dispo	sition (Neme of		, nyac	7.0	20c. Location -		wn, Stete
Baltimore,	00		1 Donetion 5			916		netory or other p		0 200	5/06/99	Dwonter	204	Manuland
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Ba	Departr Importu any inju	1	1//	11	Mar		Ga	sch's F	uner	al Hom			3.00	00701
-		23	a. P 11 Enter the	disease, or com	plications that cau	sed the deeth.					ue, Hyat		e, MD	Approximeta
	Physician		shook, or heart for	eilure. List only	one ceuse on aec	h lina.								Onset end Deeth
	/Medical	Im	mediete Ceuse (Fin	iel										
	Examiner	res	ease or condition aulting In death)		e. Renal									4 Weeks
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	physician end the buriel-transit deficial Examiner				b. Hyper	tension	n es e conseq	wanna of):						
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68	g phy es th	res	ulting In deeth) Les	it I		Due to (01	es e conseq	dende onj.						
Box	ndin use				d									
	that the death certificed by the attending detached for use early Physician/Me	Par	t II. Other significa	nt conditions o	ontributing to deat	h but not resul	lting in the u	nderlying cause	niven in	Pert I	23b. Did to	bacco uas co	ntributa to	the cause of death?
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D, 5	requires that seen signed by hould be determined by Please that the signed by Please that the signed by Please the		Coronary	Artery	Disease									
Records,	an sig										24a. Was e	n autopsy	24b. We	ere autopsy findings ellable prior to
00		_	Respirat	ory Fai	lure						perion	Heat	COL	mpletion of cause deeth?
Re	The law sta has page 2										10V	es 2 🗓 No		Yes 2□ No
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Division	tal or Attending Praid after death.  al Director: After tied in by the funere  Certification:		1 Neturel :	5 Panding	28e. Date of I (Month,	Day Year)	Injury	N N		2 🗆 No				
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Š	after after Dire		4 Homicida	determined	building	etc. (Specify,	)	,			City or Town	n, State)		
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	(3)	30	Nama end addrass	of person who	completed cause	of death /line	23a) /Time						, .,	
	(2)		ogdish C.						Roa	d. #10	3. Rowie	. Marv	land	20716
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V	Registrar		MAY 1	0 1999	Bet	1	B. ,	forces						

**4MH 16 Rev 6/95** 

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death Blackwell 10=50 AM Paul May 99 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Beath 4c. County of Death Examiner 1 Hospital
7. Aga (In yrs. last birthday) Columbia Howard Cou 5. Social Security Number Howard County General If Undar 1 Yaar 6. Sex 1 M 2 ☐ F 8. Data of Birth (Month, Day, Year) June 29 1935 9. Birthplace (Stata or Foreign Country)
Portsmouth, Va **Funeral** Months Days Hours 578 48 4559 Usual Rasidence of Decedent Yrs. Director 10a. Stata 10b. County 10c. City, Town or Location 10d. tnside City Limits r 28a-f show ahow 1 Yas 2 No Director mD. Howard Columbia 10a. Street and Number 10g. Citizen of What Country? "natural", or Items 23s or Road 20145 Soaring USA 9273 H; 11 Funeral 12 Was Decedent Ever in U,S. Armed Forces? 1 Ayas 2 □ No If Yas, Giva Year or Datas: 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, atc. 11. Marital Status flied within 72 hours effer 1 Never Merried 2 Married 21215-0020 1 ☐ Yes 2X No Specify: Specify: by 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) u.S. Senat Clerk 1284. Baltlmore, Maryland 17. Father's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) permit. Pages 1 and 2 should be fill.
Department of Health and Mentel Hy
Important: if item 27 is marked oth Be Jones walter Blackwell marie 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Same as: 10e, C, b, a Lois M. Blackwell 20b. Place of Disposition (Name of cematary, cramatory or other place) 20a. Method of Disposition

1 Deurial 2 Cremation 3 Removal from State Data 20c. Location - City or Town, Stata 5/14/99 wash., D.C. Glenwood Cemeter 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility T. Rhines Co. ohn 3030-12th. St. N.E. Wash DC 20017 un 23a Dorrt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, mock, or heart feilure. List only one cause on each line. Approximete Intarval Between Onset and Death **Physician** /Medical tmmediata Cause (Finet Sudden death disease or condition resulting in death) Examiner Dua to (or as a consequence of): Examiner myocardeal disease Coronary artery Sequentially list conditions, if any, teading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last inferention Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760. misterry of Strok Physician/Medical Due to (or es e consequance of): heavy alcohol use and eigaritte smeking mistory of 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 3 Probebly 4 Unknown 1 ☐ Yes 2 ☐ No þ 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? Completed 1 □ Yas 2 No 1 ☐ Yes 2 ☐ No or Attanding Physician: 25. Was casa refarred to medical examiner? Be 26. Placa of Death (Check only ona) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yas 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of tnjury 28c. tnjury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ANetural deeth. 1 ☐ Yas 2 ☐ No 2 Accident after deetl 3 Suicide 6 Could not be detarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Plece of Injury - At homa, farm, straat, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To tha best of my knowledga, death occurred et the time, dete end place, end due to the cause(s) end menner as stated.

2 Medicat Examiner: On tha basis of axamination and/or invastigation, in my opinion, deeth occurred at the tima, date and place, and due to the cause(s) and mannar stated. edical 29a, Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signetura and titla of certifier 29c. Licensa number

State Registrar TO-

31. Data filed (Month, Day, Year)

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30, Nama and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3 Time of Death **Physician** Month Voor CHARLES **ALEXANDER** BRANDFORD. III May 9 1999 10:30am /Medical 4e. Fecility Neme (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Doctors Community Hospital Lanham Prince George's If Under 1 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number Year If Under 24 Hrs. Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** Days 180 M 2□ F 217-36-8176 59 Yrs Director Feb. 1, 1940 Maryland Usuai Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-1 show traumetic event, the Medical Examiner must be notified at Maryland Prince George's Bowie Director 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Herns 23a 13100 Old Fletcherstown Road 20715 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Biack, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Merried 2 ☑ Married "natural", or 1 ☐ Yes 2 No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry end Mental Hygiene. Elementary/Secondary (0-12) Coilege (1-4or 5+) Electrician 12th Private 17. Father's Name (First, Middla, Last) 18. Mother's Neme (First, Middla, Maidan Sumema) Be Charles Alexander Brandford, Jr. Elsie C. Duckett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Department of Health e Important: If Item 27 Is any Injury or other tracents. Romaine Brandford/Wife 13100 Old Fletcherstown Road, Bowie, Maryland 20715 20b. Piece of Disposition (Nama of cematary, cramatory or other placa) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 M Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 1999 Clinton, Maryland 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME Na Pe 7474 Landover Road, Landover, Maryland 20785 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician sthe buriel Physician/Medical Due to (or as a consequence of) 98 USB Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by to 1 Yes 2 No 3 Probably 4 Unknown þ cete hes been sign, page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Physician: director Be 25. Was cese referred to medical 26. Piace of Deeth (Check only ona) Hospitai: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA this funeral 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Aller Attending 5 Pending investigation 1 D(Neturai al or Attending a shar death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Spacify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 加い 4 Homicide To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifies 15c Certifying Physician: To the best of my knowledge, death occurred at the time, dete end piece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) MAY 1 2 1999

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30. Name and ad

22. Registrar's Signature

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ress of person who completed ceuse of deeth (Item 23a) (Type, Print)

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month **Physician** KAYMOND WHELKER BROWN 05.47.00 5 1999 11 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** CARROLL ESTMINSTER GENERAL HOSPITAL If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 10M 20 F Yrs. MD Director Usual Rasidence of Decedant death with the Meryland 10a. Stata 10b. County permit. Pages 1 and 2 should be filed within 72 hours efter death with the Menylam Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Mexical Examiner must be notified at any Injury or other traumatic event, the Mexical Examiner must be notified at any once. 10c. City, Town or Location 10d. Inside City Limits MD 1 Yes 2 No Funeral Director ARROLL ESTMINSTER 10g. Citizen of What Country? 10e. Street and Number MEADOW USA Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, Whita, atc. 11. Marital Status 2 Married ☐ Yas 2 No Yas, Giva Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorced Year or Datas: Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry POLICE Elamantary/Secondary (0-12) Collega (1-4or 5+) BALTIMORE CO. 17. Fathar's Name (First, Middla, Last) 18. Mother's Nama (First, Middle, Meiden Surnama) Be C. HOOPER W. BROWN SR EDNA 2 KAYMOND 195 Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1375 GEEN MEADOW LANE
WESTINIUSTER, MARYLAND 2/158

20b. Place of Disposition (Name of Commanday Comman 19e. Informant's Name/Raiationship (Type, CAROLYN Brown WIFE 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Removal from State MARYS CEMETER 199 4 ☐ Donation 5 ☐ Othar (Specify) of Funaral Sarvice Licensee 22. Name and Address of Facility CIHS FUNERAL HOME & CHAPEL Part Enter the disaesa, or complications that caused the death. Do not enter the mode of dying, such as cardi ROAD MARY LAND Approximate Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final minutes disaasa or condition rasulting in death) Examiner Examiner or Attending Physicien: The law requires that the death certificate be asscuted Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Diseasa or injury that initiated events rasulting in daath) Last Dua to (or as a consequence of): P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): been signed by the attendin should be deteched for use Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown Division of Vital Records. þ Be Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yas 2 No 1 ☐ Yes 2 ☑ No 25. Was casa rafarred to medical 26. Place of Death (Check only one) Hospitai: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Dete of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 24 hours after death.

Funeral Director: A 2 Accidant invastigation 28a. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicida Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Cartifier Medical completely (Check only one)

State Registrar

31. Data filad (Month, Day, Year)

29b. Signatura and titla of certifier

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217 WASHINGTON HGTS. 32. Registrar's Signature

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29c. License number

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29d. Data signed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene

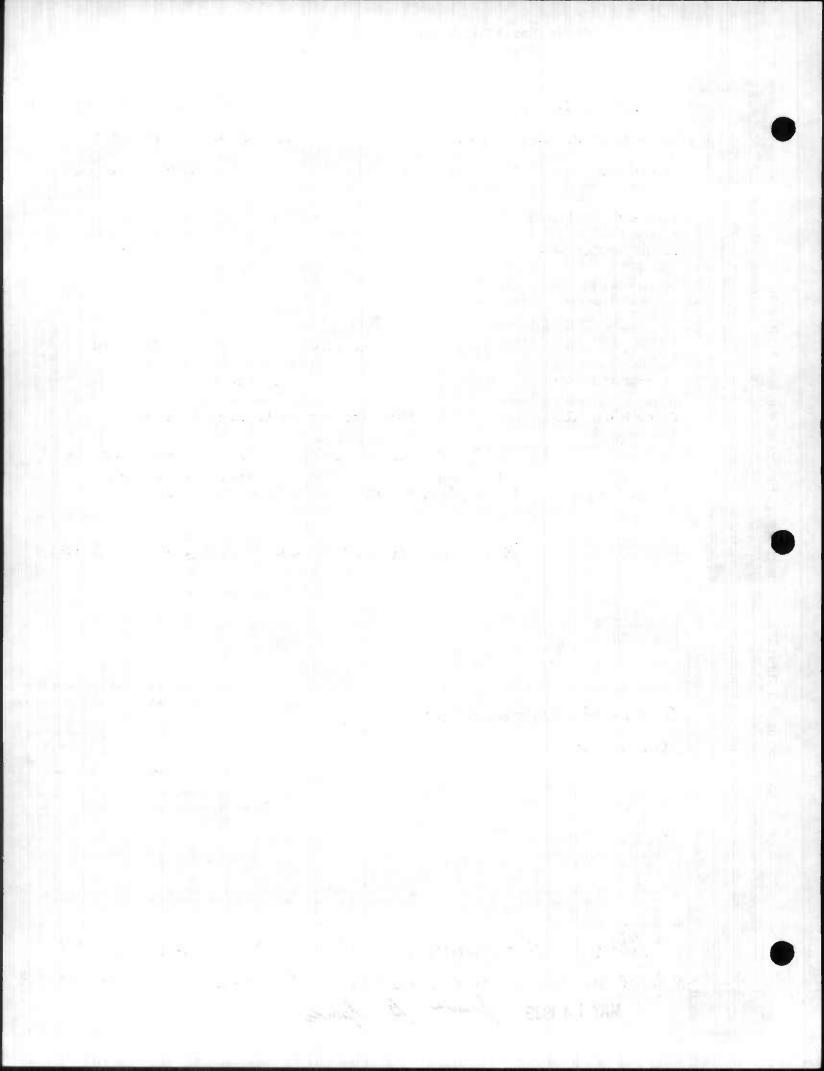
Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1999 11, 6:00 am Ruth Helen Burke May /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner Robosson Court Nursing Center Randallstown Baltimore If Under 1 Year 8. Dete of Birth (Month, Day, Year) Sept 2,1918 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 € F 80 Yrs. 213-16-1653 **Director** Maryland Usual Residence of Decedent with the Meryland 10a State 10h County 10c. City. Town or Location 10d Inside City Limits show rsi', or items 23a or 28s-f show Examiner must be notified at 1 ☐ Yes 2 No Upperco Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of Whet Country? 15902 Trenton Road 21155 USA Funeral death 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Maritai Status nit. Peges 1 and 2 should be filed within 72 hours efter or artment of Health and Mertel Hygiene. ortant: If item 27 is marked other than "natural", or ite injury or other traumate event, the Meul all Examinate injury or other traumate event, the Meul all Examinate. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 White If Yes, Give Yeer or Dates: 1 Yes 2 XNo Specify: Specify: by 3 ☐ Widowed 4 ☑ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Flementery/Secondary (0-12) College (1-4or 5+) Housewife Own Home 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Arthur Cullison Lola White 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Betty Hann, sister 15715 Hanover Rd, Upperco, MD 21155 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removel from State Department of Important: If any injury or 5/14 4 □ Donation 5 □ Other (Specify) Carroll Cremations Hampstead, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licansee Eline Funeral Home 934 South Main St, Hampstead, MD 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** · PROBABLE ASPIRATION PREUMONIA Immediate Cause (Final disease or condition resulting in death) بالافرائة Examiner Examiner and I-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as e consequenca of): physician ar s the burial-t P.O. Box 68760. Physician/Medical Due to (or es a consequence of): 88 esn Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 TYes 2 No ORD PHALYNGEAL DYSPHAGIA Division of Vital Records, 24b. Were autopsy findings available prior to 24e. Was an autopsy performed? Completed DEMENTIA completion of cause of death? 1 Yes 2 2 No 1 Tyes 2FTNo or Attending Physician: funeral director, 25. Was case referred to medical 28. Place of Deeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Certification: 5 Pending Investigation 1 Neturel efter death. Director: Aft 1 Yes 2 No 2 Accident 6 Could not be determined 28e. Placa of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide n 24 hours e 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. edical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred of the time, date end place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and fittle of certifier 1ce HTTENDING 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 5310 OLD COURT RD. PANDALL TOWN MO 21133 P.R. DESAL MD; 31. Date filed (Month, Day, Year)

32. Registrar's Signeture

MAY 1 4 1999

State Registrar



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Date of Death 3. Time of Death Month BATR CLINTON ELVIN MAY 13 1999 0010 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death CARROLL WESTMINSTER CARROLL COUNTY GENERAL HOSPITAL If Under 24 Hrs If Under 1 Year 8. Dala of Birth (Month, Day, Year) OCT 27 1916 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours MARYLAND 10 M 2□F 82 205-16-3497 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLAND CARROLL TANEYTOWN 1 Yas 2 No 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 42 FAIRGROUND AVENUE 21787 UNITED STATES 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11 Marital Stalus Bleck, White, etc. 1 X Yes 2 No If Yes, Give 1945 Year or Dates: 1945 1 Never Married 2 Married 1 Yas 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) WANTZ CHEVROLET SERVICE STATION ATTENDANT 8 0 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HOWARD CLINTON BAIR EMMA LYDIA HAHN 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) TANEYTOWN, MD. 21787 ALMA G. BAIR / WIFE 42 FAIRGROUND AVENUE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) MAY 17 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State TANEYTOWN, MARYLAND TRINITY LUTHERAN CEMETERY 1999 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility SKILES FUNERAL HOME TANEYTOWN, MD. 21787 136 EAST BALTIMORE STREET 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did jobecco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy

**Physician** /Medical Examiner

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**Physician** 

/Medical

Examiner

**Funeral** 

Director

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"natural".

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiena. Important: if item 27 is marked other than 1 any injury or other traumatic event, the Med Botcal.

Director

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Examiner

Physician/Medical

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Medical

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72 hours after

Baltimore, Maryland 21215-0020

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Inpatient 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 | Homicide 29a. Certifier

(Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and tyle of certifier

31. Date filed (Month, Day, Year)

29c. License number 29d. Date/signed (Month, Day, Year)

and address of person who completed cause of death (Item 23a), (Type, Print)

West minster No 2115 wash.

State Registrar

MAY 14

32. Registrar's Signature

9913102043 UNIT# 03-89-64 BAIR,ELVIN CLINTON 359-B RAJPARA,NATVARLAL K 10/27/1916 M INP 05/11/99

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month MAY 17,1999 **Physician** Yaar ETHEL ELIZABETH BAKER 10:50A.M. /Medical 4a. Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 237008 LEONARDTOWN/HOLLYWOOD ROAD HOLLYWOOD ST.MARY'S Hours Min. 8. Data of Birth (Month, Dey, Year)
JAN • 27, 1949 5. Social Sacurity Number 7. Aga (In yrs. last birthday) If Under 1 Yeer 9. Birthpiace (State or Foreign **Funeral** Months Days 1□M 2□F MARYLAND 219-48-9447 50 Yrs Director Usual Residence of Decedani death with the Maryland 10a Stata 10b County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or flems 23s or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MARYLAND ST.MARY'S CHAPTICO 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? P.O.BOX 352 20621 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) Race - American Indian, Biack, White, atc. 11. Maritai Status permit. Peges 1 and 2 should be filed within 72 hours after d. Department of Heelth and Mentel Hygiene. Important: if item 27 is marked other than "natural; or item any injury or other traumatic event, the Medical Exercises of the contract of the contrac 1 Never Married 2 Married 1 ☐ Yas 2 ☐ XNo If Yes, Giva Yeer or Datas: Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: BLACK Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work done during most of working lifa. DO NOT use retired) Elamentary/Secondary (0-12) Collega (1-4or 5+) CHILD CARE PROVIDER SELF EMPLOYED 6 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nema (First, Middla, Meidan Sumama) 8 GEORGE FRENCH BAKER ANNA LOUISE BUSH 19a. Informant's Name/Raiationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) ANGELA D. THOMAS-SISTER P.O.BOX 334 CHAPTICO, MD. 20621 20b. Placa of Disposition (Neme of cemetary, cramatory or othar place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Bunai 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) QUEEN OF PEACE CEM.5-20-99 HELEN, MARYLAND 21. Signature of Fugeral Service License Name and Addrass of Facility RAYMOND FUNERAL SERVICE, P.A. 23a. Part 1. Enter the disaasa, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batw Onset and Death **Physician** /Medical Immediate Causa (Final disaasa or condition resulting in deeth) non Examiner Due to (or es a consequence of): Examiner physiclen and the burial-transit Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical Dua to (or es a consequance of): ettending esn ed by the detached Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by t 1 Yes 2U No 3 ☐ Probably 4 ☐ Unknown by should 24b. Wara autopsy tindings available prior to completion of cause of death? 24a. Was en eutopsy performed? Completed page 2 20 No has certificate To the Hospital or Attending Physician: within 24 hours effer deeth.

To the Funeral Director: After this certific, completely filled in by the funeral director. 25. Was casa rafarred to medical Be 26. Pleca of Daath (Check only ona) avaminar 1 ☐ Yas 2 No Other: 4 Nursing Homa 5 Rasidenca 6 Other (Specify) Mother'S Note: 2 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28a. Dete of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Tima of Certification: 28c. Injury at Work? Natural 5 Panding 1 ☐ Yas 2 ☐ No invastigation 2 Accidant 6 Could not be datarmined 3 Sulcide 28e. Plece of Injury - At homa, farm, streat, fectory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 4 Homicide 29a. Certifier (Check only one) Sertifying Physician: To tha best of my knowledge, death occurred at tha time, date and pleca, and due to the cause(s) and mannar as steted.

| Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and mannar stated. Medical 29b. Signature and this of certifier 29c. License number 29d. Date signed (Month, Dev. Year)

of daath (Itam 23a) (Type, Print)

boe

32. Registrar's Signature

Hollywood, md. 20636

State Registrar 30. Name and

31. Date filed (Month, Dey, Year)

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# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

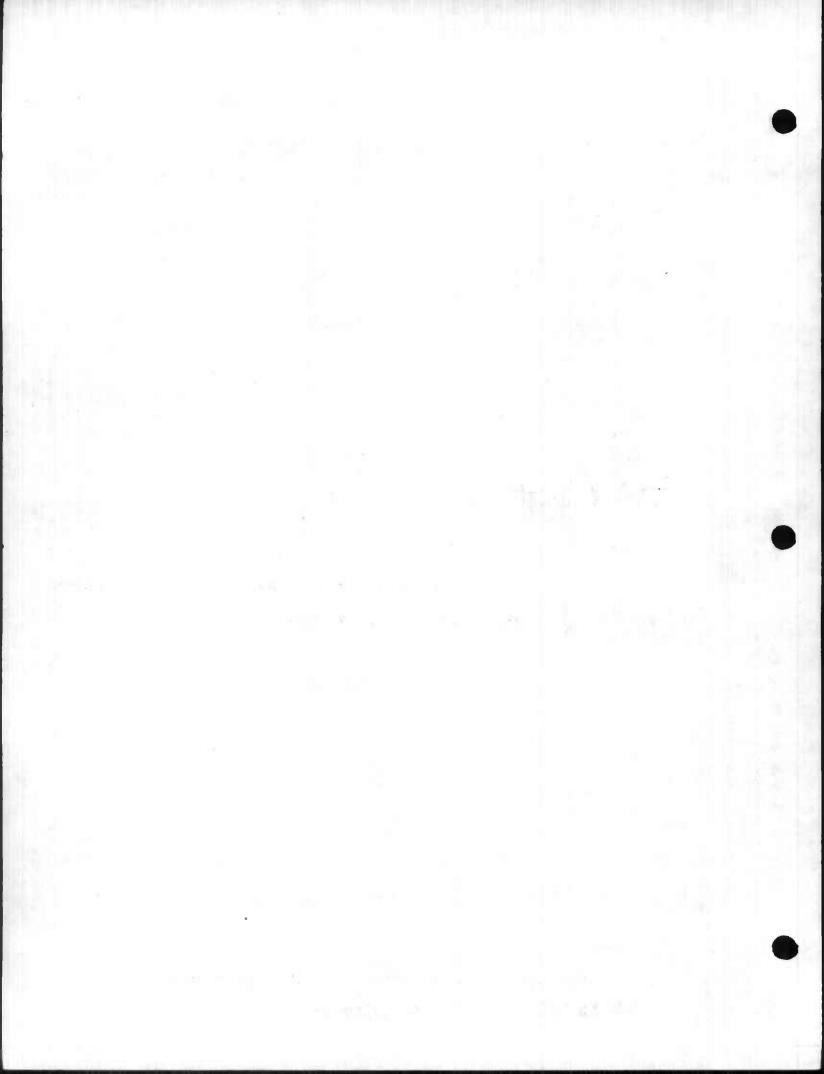
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/Medi		Rita Elizabe						Мау	13°, 1	999 1	2:55 AM
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Funeral Director		214-05-9544 Usual Residence of Decedent	6. Sex 7. 1  M 2  F 7.	Age (In yrs. I	Yrs.	Months Days		8. Date of Birth (Month, Day 04-Jan-		9. Birthplace Country) Maryla	e (State or Foreig
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ing P	lon:	27. Manner of Death 1 ☑ Neturel 5 ☐ Pend		ijury De <i>y Year)</i>	28b. Time of Injury	28c. Inju Wo		28d. Describe ho	w Injury occur	red	
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eral tor	SACRED HEART I 5. Social Security Number 219-14-5154	6. Sex		rs. last birthdi Yrs	Month	der 1 Year ns Days	CUMBE If Under 24 Hr Hours Mir	8. Date of B (Month, D			lace (Stete or Foreign try) YI.AND
	Usual Residence of Decedent  10a. Stete 10b. Count	v	100	City, Town or	r Location						0d. Inside City Limits
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by Funeral	11. Merital Stetus  1 Never Merried 2 Ma  3 Widowed 4 Divorce	rried 12.	Wes Decedent Ever Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: WW1		If Yes, s	cedent of h	lispanic Origin? ( an, Mexican, Pue	Specify Yes or N rto Rican, etc.)	lo- 14. P	lace - Americ lack, White,	etc.
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_	19e. Informent's Neme/Relation SHARON CLARK	ship (Type,	Print) DAUGHTEF				and Number or F				Code) 1502
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X	29b. Signature end title of certific	er			2	29c. Licens	se number		29d. Date sig	ned (Month,	Dey, Year)
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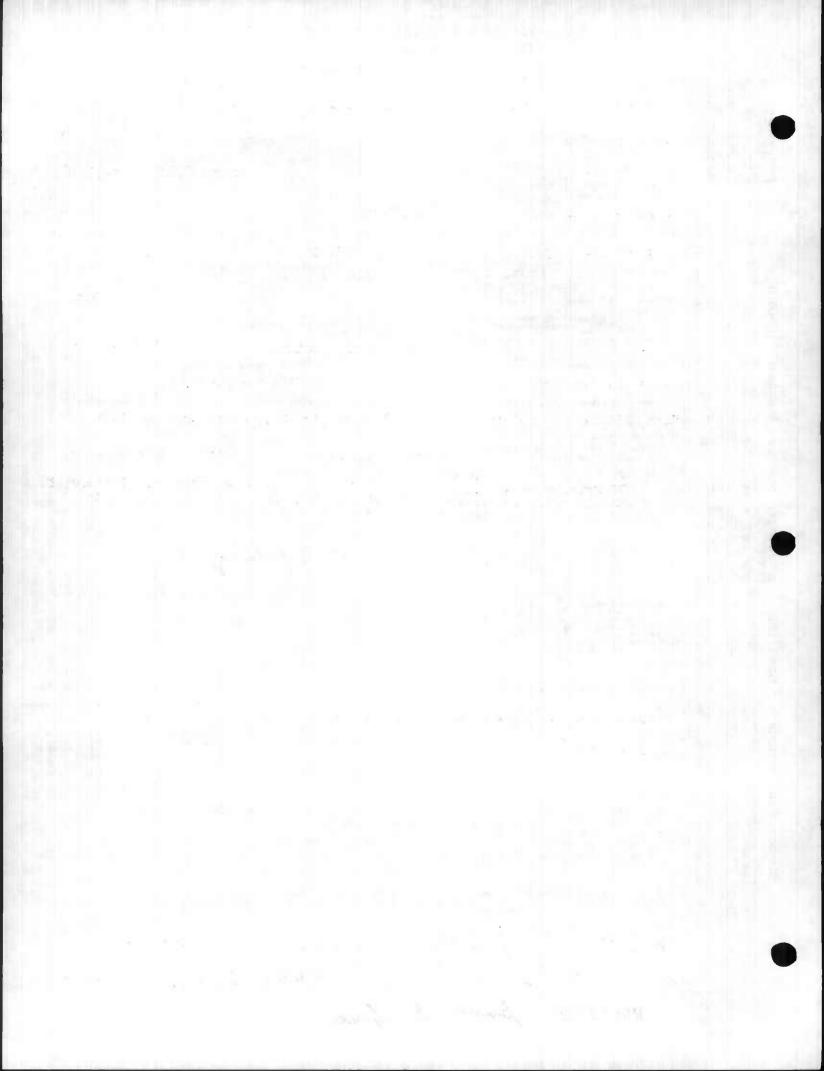
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** May 9, 1999 JAMES WALTER BETTS JR. 12:15 AM /Medical 4a Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Salisbury 1108 Riverside Dr. Wicomico If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 M 2 □ F 212-10-0718 92 **Director** October 17,1906 Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Expreiser must be notified at Wicomico Salisbury 1 ☐ Yes 2 ☐ No Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1108 Riverside Dr. 21801 USA Funeral death Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Was Decedent Ever In U,S. Armed Forces? Bleck, White, etc. 72 hours after 1 ☐ Yes 2X No If Yes, Give 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates: Specify. White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If itsm 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Telephone Co. Maintenance Engineer 11 traumatic svent, 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ella Lee Mitchell James Walter Betts Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Sara Elizabeth Betts/Wife 1108 Riverside Dr., Salisbury, MD 21801 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 8 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State pemit. Page Department of Important: If any injury or pnce. 5/12/99 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Parsons Cemetery 21. Signature on Funeral Service Licensee 22. Name and Address of Facility MOIOSI Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Glocalmorph arrice 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical of the lung Immediate Cause (Finel 14n disease or condition resulting in death) cinoma Examiner Due to (or es e consequence of): Examiner that the death certificate be executed physician and s the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b of food Secondary by 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy Completed peen 1 Yes 2 No 1 ☐ Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Deeth Date of Injury (Month, Day Year) 28c. injury et Work? 28d. Describe how injury occurred 28b. Time of Certification: i or Attending P. safter death. 5 Pending Investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide e Hospital o 24 hours af Funeral Di 150 Certifying Physicien: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as stated.

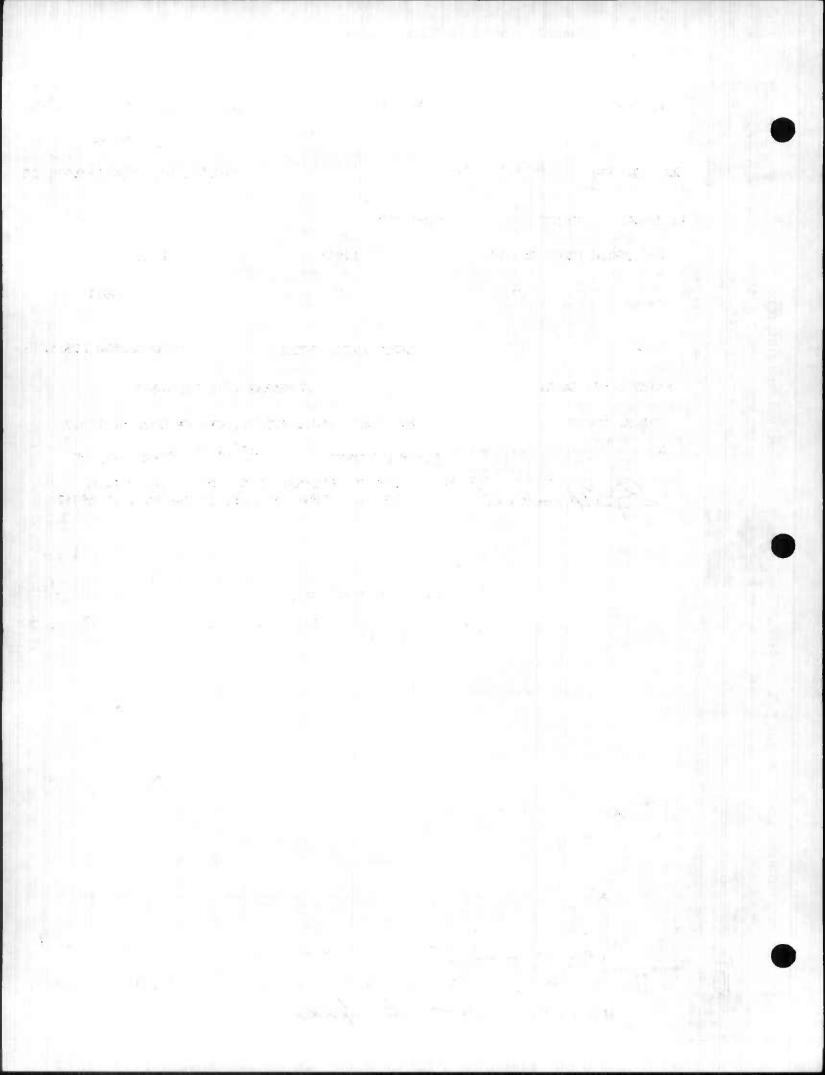
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. 29a. Certifier Medical To the To the To the I 29d. Dete signed (Month, Dey, Year) 29c. License number 29b. Signeture end title of 024986 10 30. Name end address of person who, completed cause of death (Item 23a) (Type, Print) Or. suite Bio: Salisburg md. 21801 Robert J. Relly Mp Chk. 560 RIMASIDE 32. Registrar'a Signature 31. Date filed (Month, Day, Year) State Registrar MAY 1 2 1999

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# Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

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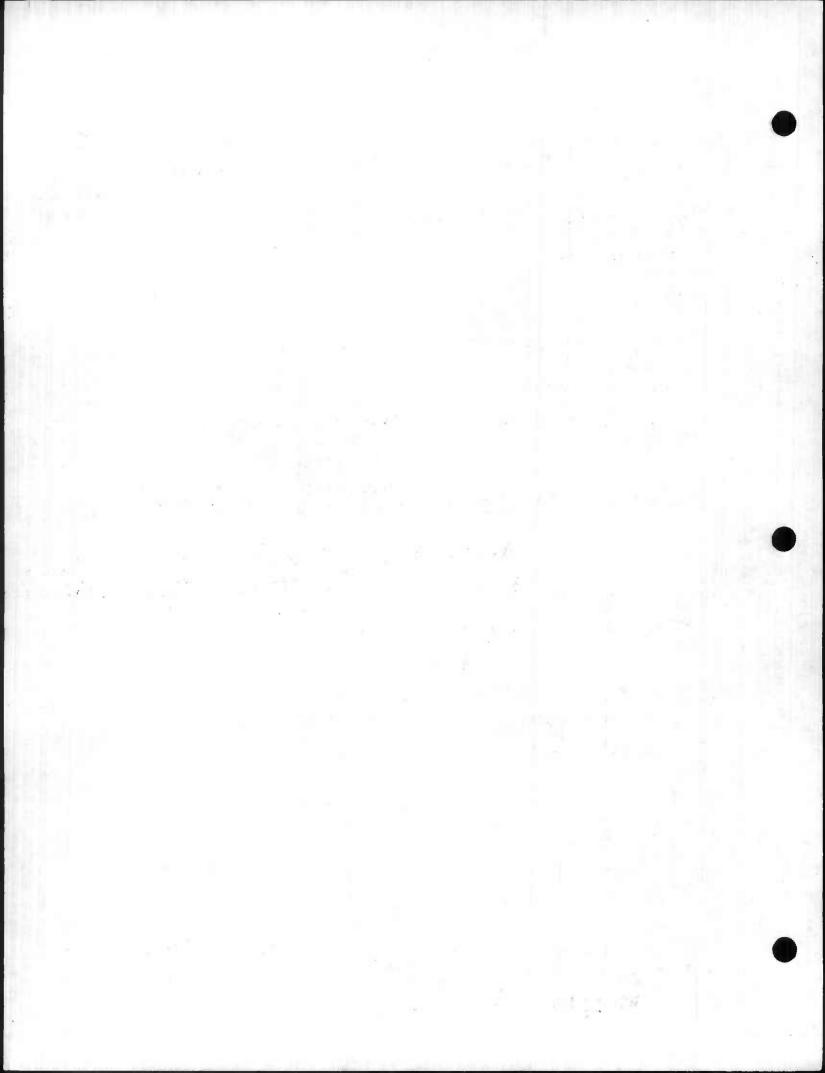


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dale of Death 3. Tima of Death Year Month **Physician** George Webster Bradford May 6 1999 1600 /Medical 4b, City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Harford Memorial Hospital Havre de Grace Harford If Under 24 Hrs. Hours Min. If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 MM 2□ F Yrs. Director 219-16-2633 MD 80 08/09/1918 Usual Residence of Decedent death with the Maryland 10a Stale 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 □ No **Funeral Director** MD Harford Aberdeen 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 619 Colaine Drive USA 21001 or herna 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after Yes 21 No 1 ☐ Never Married 2 ☑ Married 21215-0020 1 Yes 2 No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. than Elementary/Secondary (0-12) College (1-4or 5+) 8th Truck Driver Phillips 66 (Oil Co.) other Baltlmore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) .. Pages 1 and 2 should be fil tment of Health and Mental H tant: If Nem 27 Is marked off jury or other traumatic even Be Alexander T. Bradford Deborah Baldwin 19a. Informant's Name/Reiatlonship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mary E. Bradford- Wife 619 Colaine Dr. Aberdeen, MD 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removel from State 4 □ Donation 5 □ Other (Specify) Department of Important: If eny Injury or Wesleyan Chapel Cemetery 5/10/99 Havre de Grace, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Mitchell-Smith Funeral Home, P.A. 123 S. Washington St., Havre de Grace, MD 21078 Rany. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiralory arrest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner hows Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medicai mar 23b. Did tobacco use contribute to the cause of death? Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 12 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings evailable prior to completion of cause of death? 24e. Wes an autopsy 1 Yes 2 LNO 1 Yes 2 NO Division of Vital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Impalient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Naturel 5 Pending 1 Yes 2 No investigation 2 Accident within 24 hours after deal To the Funeral Director: 6 Could not be delemined 3 Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29e. Certifier 12 Certifying Physician: To lhe best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 100 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 13 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Tre State 1999 Registrar

**DHMH 16 Rav 6/95** 

, George BRod ford



State of Maryland / Department of Health and Mental Hygiene (1)

Certificate of Death 2. Date of Death 3. Time of Death 0720 AM

**Physician** /Medical Examiner

**Funeral** Director

10e. Sfate Direct

the Marylend r 28a-f show with

7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r death illed within 72 hours aftar altimore, Maryland 21215-0020 . Pages 1 and 2 should be file fment of Heelth and Mentel H-tant: If them 27 is marked oth jury or other traumatic even permit. Page Department of Important: If any Injury or once.

**Physician** /Medical Examiner

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Physician/Medical

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Certification:

Box 68760. certificate be

Division of Vital Records,

or Attending Physician:

18

24 hours a

within 2 the

1. Decedent's Neme (First, Middle, Last) MAY 10,1999 James Daniel Bollinger 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) VAMHCS, FORT HOWARD FORT HOWARD BALTIMORE 5. Social Security Number If Under 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) May 5, 1940 Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthdey) Months Days Hours 1)(DM 2 F 219 34 0280 59 Yrs Maryland Usual Residence of Deceden 10b. County 10c. City, Town or Location 10d. inside City Limits 1 No Yes 2 No Maryland Harford Havre de Grace 10e. Sfreet and Number 10g. Citizen of What Country? 10f. Zlp Code 106 Seneca Avenue 21078 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Maritai Status 1 12 Yes 2 □ No
If Yes, Give
Yeer or Detes: 1958-61 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Spot welder 12 Sheet Metal 18. Mothar's Name (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Last) 8 Herman J. Bollinger Olivia Curnoles 2 19b. Malting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Helen L. Bollinger (Spouse) 106 Seneca Ave., Havre de Grace, Maryland 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State Date ₩Buriat 2 Cremation 3 Removal from Stafe Holly Hill Memorial Gdns:5/12/99 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Fupeful Service Licensee 22. Name end Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 Aperaeen, Marytana 2100123a. Parti. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Finat diseese or condition resulting In death) LUNG CANCER WITH METASTASIS ONE MONTH Due to (or as a consequence of): Examiner

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

Due to (or es a consequence of) Due to (or as e consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

DIABETIS MELLITUS

24e. Was an autopsy performed? 1 Yes 20No

26. Plece of Death (Check only one)

24b. Were autopsy findings eveilable prior fo completion of cause of deeth?

25. Was case referred to medical examiner? 1 Yes 2 No

27. Magner of Deeth

1 Netural

2 Accident

4 ☐ Homicide

3 Suicide

5 Pending investigation

Hospitel:

28b. Time of 28a. Dete of Injury (Month, Day Year)

28e. Place of Injury - At home, farm, streef, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 tnpatient 2 □ ER/Outpetient 3 □ DOA 28c. Injury at Work? 1 Yes 2 No

28f. Location (Street end Number or Rural Route Number, City or Town, State)

28d. Describe how Injury occurred

29a. Certifier (Check only one)

6 Could not be determined

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the filme, date and piece, and due to the cause(s) and menner stated.

29b. Signature and fifle of certifier www au, 29c. License number

29d. Date signed (Month, Day, Year)

MAY 10,1999

23b. Did tobacco use contribute to the cause of death?

toyes 2 No 3 Probably 4 Unknown

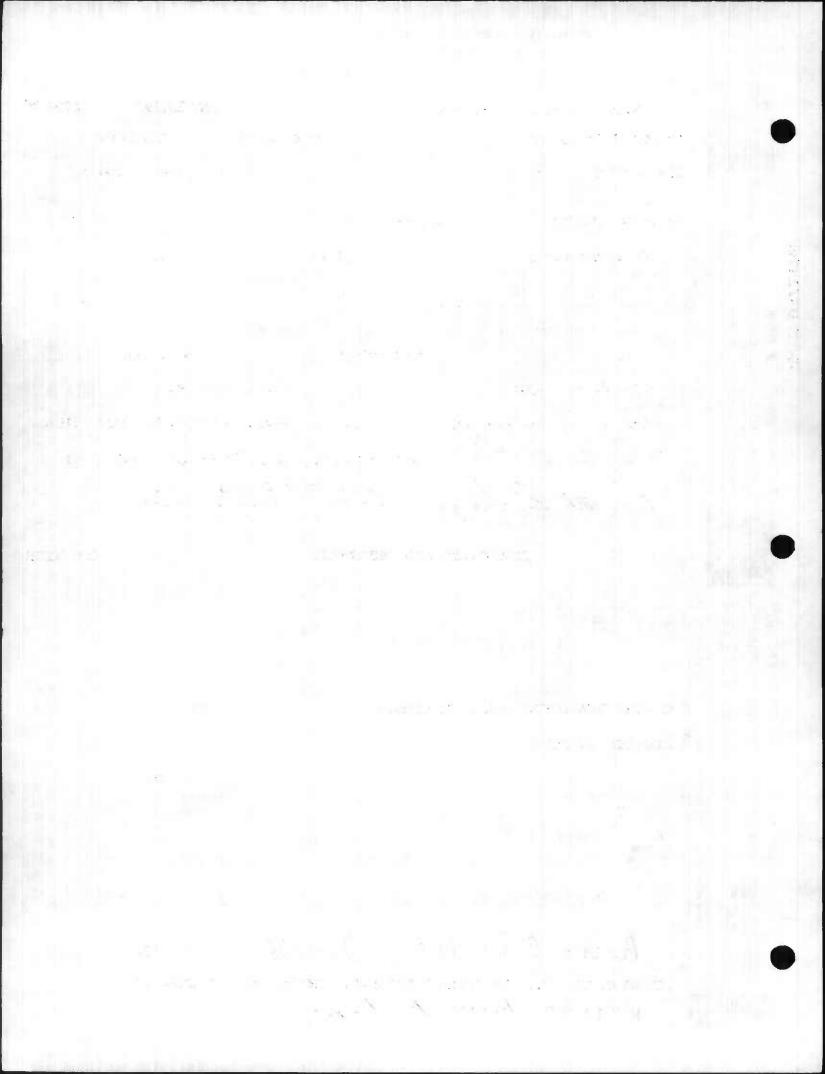
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9600 NORTH POINT ROAD, FORT HOWARD, MARYLAND 21052 AURORA C. TAN MD., 31. Date filed (Month, Dey, Year,

Registrar

2. Registrar's Signature MAY 1 1 1999

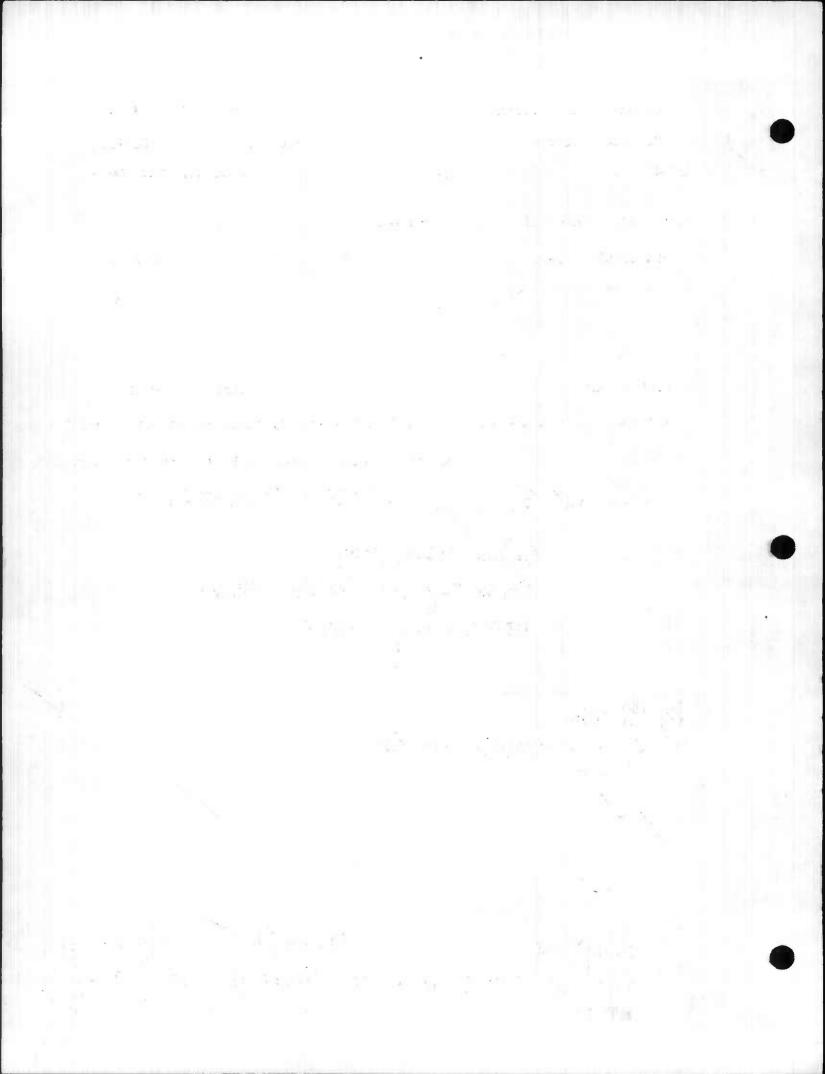




State of Maryland / Department of Health and Mental Hygiene

			(	Certificate of	Death	Re	g. No.	1104
		Decedent's Nama (First, Middla, Last)				2. Data of Death	Day Yaar	3. Tima of Death
ш	Physician /Medical	Nelson John Bowers				May	11 1999	5:15p.m
	Examiner	4a Facility Nama (If not institution, giva street and number)			4b. City, Town, or Lo	ocation of Death	4c. County of Deeth	
7		683 Custis Street			Aberdee	n	Harfor	rd
	Funeral Director	5. Social Sacurity Number 6. Sax 7. Aga (	In yrs. last birth	Months Davs	If Undar 24 Hra. Hours Min.	8. Deta of Birth (Month, Dey, Feb. 24	9. Birth Con.	ppiaca (Stata or Foraign intry)
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	anyla ahov		0c. City, Town				0.00	10d. Insida City Limits
	or 28a-f a	Maryland Harford	Aber				(115.16	
	terdeath with the Marylan items 23e or 28e-f show me must be notified at the metric of the control of the contr	10e. Street and Number		10f. Zip Coda		10	g. Citizan of What Cou	intry?
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	er de	11, Meritel Status 12. Wes Dacedant Ev Armed Forcas?	arın U,S.	<ol> <li>Was Decedent of H If Yes, specify Cub</li> </ol>	an, Maxican, Puerto	Rican, etc.)	Black, Whita	
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21215-0020		15. Decedant's Education	16a D	Decedant's Usual Occup	pation		16b. Kind of Businass/h	ndustry
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Maryland	d 2 should the end Men 7 is marke traumatic	19e. Informant's Name/Reletionship (Type, Print)	19b. f	Mailing Addrass (Street	end Number or Rur	al Routa Number,	City or Town, Stala, Z.	ip Coda)
	1 and 1 Health Pm 27 I	Florine C. Bowers (Spouse)		83 Custis S			Maryland	21001
ore	of Healt of Healt fitem 2	20a. Method of Disposition 1 ☑ Buriai 2 ☐ Cramation 3 ☐ Ramoval from Stata	20b. Placa of C cematary.	Disposition (Nama of , crametory or other pla	ce)	Data 2	20c. Location - City or 1	own, Steta
Ē	Pages ment of I ant: If its ury or o	4 □ Donation 5 □ Othar (Specify)	Harford	d Memorial	Gardens 5	/14/99	Aberdeen,	Maryland
Baltimore,	permit. Pages Department of I important: If Its eny Injury or o	21. Signeture of Funeral Service Licenses	2	22. Nama and Addra		7 77	70.7	
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Re	0 - 5 -	1/				1 □ Y£	as 2 No 1	I Yas 2 No
Vital Records,	certificate rector, pag	25. Was case referred to medical			28. Place of Dea	th (Check only on	a)	
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l of	aling Phys h. After this funeral di	27. Manyler of Death 28a. Dete of injury (Month, Dey )	(eer) 28b. Tir	ma of 28c. Inju	ry at	28d. Dascribe ho	w injury occurred	
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	is after at Direction Cert							
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	o t with	29b. Signature and title of certifier		01	160/2	/ "	5/4/00	7
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	100	30. Numbered address of parson who complated causa of dea	th (Itam 23a) (T	Type, Print	Unine	Pa Ca	me the	N (GD)
		31. Date lied (Month, Day, Year) 32. Registrar	s Signatura	n Kivi	KIDAIL	N. W.	10.10	1301
	State Registrar	MAY 1 1 1999	21	. down	(1		(ANA)	NOTX

DHMH 16 Rev 6/95



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) 4c. County of Death Joseph Loyd Bigham Malan 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 204 Darlington Avenue Aberdeen Harford ADETUCE11 If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Feb. 4, 1927 If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days 1₩ M 2□ F Yrs 420-26-8933 Alabama Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Harford Aberdeen 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 204 Darlington Avenue 21001 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ⊠ Yes 2 □ No If Yes, Give Year or Date\$ 953-61 1 Never Married 2 Married 1 Yes 2 No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Military U.S. Army 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Joseph Bigham Lura Evans 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Donna W. Bigham (Spouse) 204 Darlington Ave., Aberdeen, MD 21001 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriai 2 ☐ Cremation 3 ☐ Removal from State Harford Memorial Gardens 5/7/99 4 ☐ Donetion 5 ☐ Other (Specify) Aberdeen, Maryland 22. Name and Address of Fecility 21. Signeture of Funerel Service Licensee Tarring-Cargo Funeral Home, P.A. 333 South Parke St., Aberdeen, MD 21001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervai Between Onset and Death polumary disease Immediate Cause (Finel disease or condition resulting in death) Due to (or es e consequenca of):

Physiciän /Medical Examiner

death certificate be executed

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Box 68760,

Division of Vital Records, P.O.

Examiner

Physician/Medicai

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Certification:

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**Physician** 

/Medical

**Examiner** 

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ahow

r than "natural", or items 23s or 28s-f show the Medical Exeminer must be notified at

parmit. Pages 1 and 2 should be filed within 72 hours efter Department of Health and Mentel hygiene. Important: If item 27 ia marked other than "natural", or item any injury or other traumatic event, the Medical Executa-

Baltimore, Maryland 21215-0020

death with the Marylend

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or Injury that initiated events resulting In death) Last

Due to (or as a consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given In Part I.

23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 X Y68

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of deeth?

26	. Place of De	ath (C	heck only ope)	
Other:	4 Nursing	Home	5 Mesidenca	8 Other (Specify)
njury at		28d.	Describe how Inj	ury occurred

1 Yes 2 No

1 ☐ Yes 2 N	0
27. Manner of Death	
Naturei	5 Pen
2 Accident	inve

25. Was case referred to medical

5 Pending investigation 6 Could not be detarmined

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Piaca of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

26. Place of Deat

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

3 ☐ Suicide

4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, end due to the ceuse(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of cartified

who completed cause of deeth (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

To the Hospital or Attending I within 24 hours effer death.

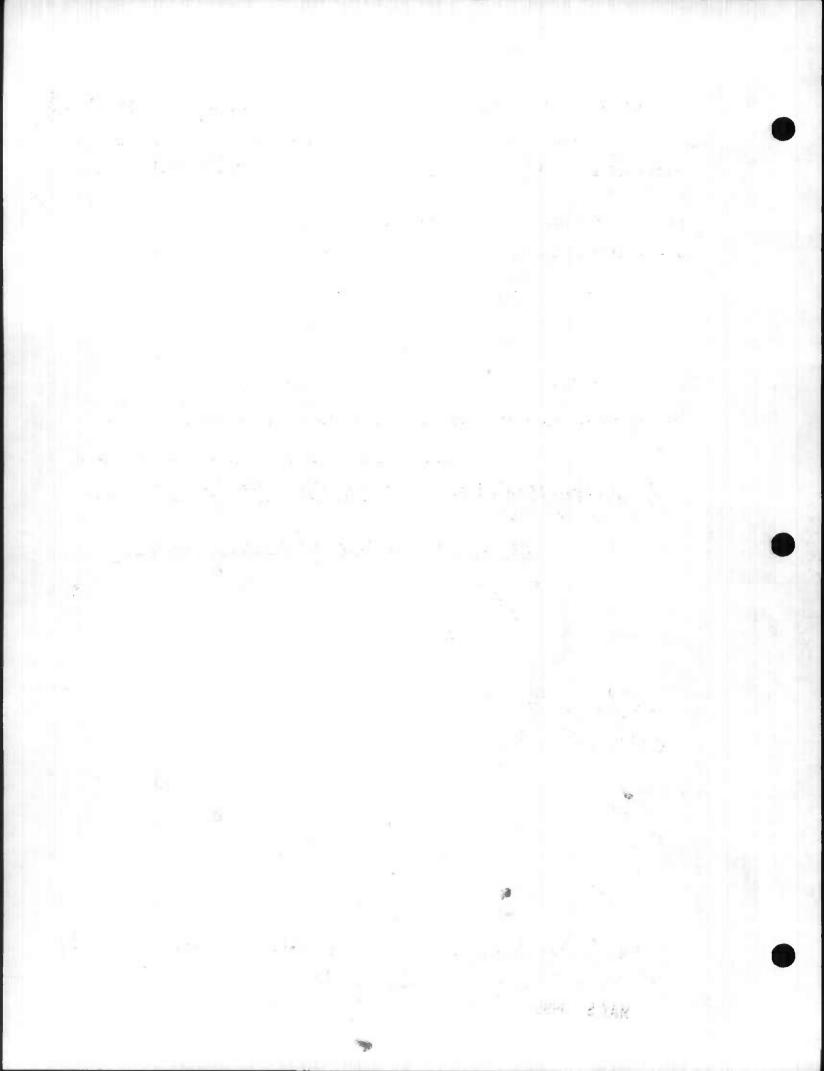
To the Funeral Director: After

State Registrar

30. Neme end eddress of Walmi 31. Date filed (Month, Day, Year)

MAY 5 1999

**DHMH 16 Rev 6/95** 



State of Maryland / Department of Health and Mental Hygiene

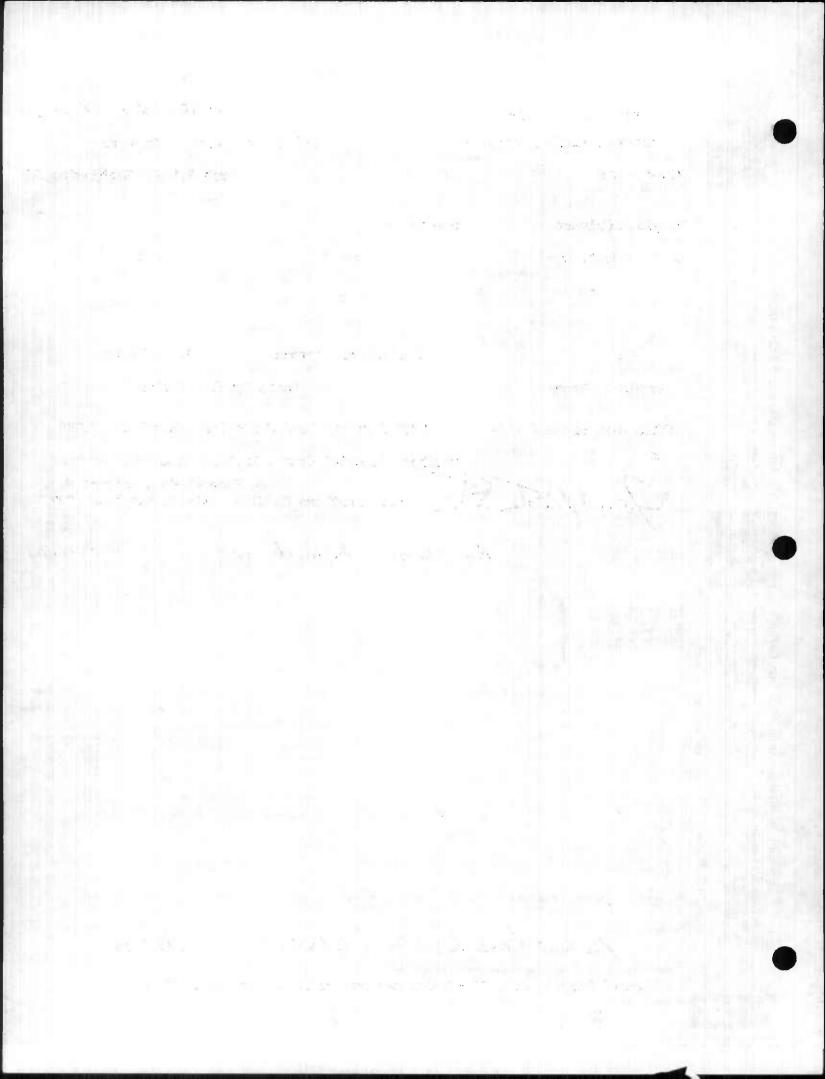
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iner	4a	a Facility Nama	(If not institution	on, give s	treet and nun	nber)				4b. City, Town,	or Location	of Death	4c. County	of Death	
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DHMH 16 Ray 6/95

State of Maryland / Department of Health and Mental Hygiene

				Cert	ificate	of Death		Reg. No.		1101
	1. Decedent'a Neme (First, Middle, L	ast)					2. Date of De	eth		3. Time of Death
Physician							Month	16, 19	Year 99	2156 p.m
/Medica Examine	An English, blome /// net /net/hitlen a	ive street end number)		-		4b. City, Town, or				DIO DIN
	Calvert Memori	al Hospita	ıl			Prince 1	Frederic	c Ca	lvert	
Funeral	5. Social Security Number 6.		ge (In yrs. last	birthday)	If Under 1	Year If Under 24 Hrs	8. Date of Bir			iece (State or Foreign try)
Director	213-46-5689 Usual Residence of Decedent	1 <b>203</b> M 2□ F	50	Yrs.	Months	Days Hours Min	March	3,1949		ington,DC
yland	10a. State 10b. County		10c. City, T	own or Loc	ation				10	0d. Inside City Limits
Mar F-1 si	Maryland Calvert		Sunde	erland	ł					1 Yes 2 No
vith the Ma	10e. Street and Number				10f. Zip C	ode		10g. Citizen of	What Coun	try?
th wi	5890 Hardesty Ro	ad			206	89		U. S	. A.	
and 21215-0020  be lifed within 72 hours after death with the Maryland stall Hygiene.  d other than "natural", or items 23s or 28s-f show event, the Madical Example must be notified at the Completed by Europe must be notified at the Completed by Europe in Discourse.		12. Wes Decedent Armed Forces? 1  Yes 2 1 If Yes, Give Year or Dates:			es Deceder Yes, specify	t of Hispenic Origin? ( Cuban, Mexican, Pue No Specify:	Specify Yes or No rto Rican, etc.)	- 14. Rad Bla Specifi	e - America ck, White, o	etc.
1 21215-002 led within 72 hours system types on matural, come than "natural, come than "natural, come than "natural Example Company", company that the tent of the	15. Decedeni's		1	6a. Decede	nt's Usual (	Occupation	arkin a	16b. Kind of B		
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Maryland d 2 should be lie th and Mental Hit th and Mental traumatic event	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailing	Address (S	Street and Number or F	Tural Route Number	er, City or Town	State, Zip	Code)
lore, Maryls ges 1 and 2 should to of Health and Mer or other traumatic	Billie Jean Brown	n / Wife		5890 I	lardes	ty Road Su	nderland	, Maryl	and	20689
Ore of H of H or oth	20a. Method of Disposition 1 □ Burial 2 □ Cremetion 3	Removel from State	20b. Place ceme	e of Disposi etery, cremi	tion (Name atory or othe	sty Road Su of or placa)	MayDete	20c. Location	City or To	wn, State
Peg ment ant: I	4 Donation 5 Other (Spec		South	hern M	<i>lemori</i>	al Grdns.	19,1999	Sunkir	k, Ma	ryland
Baltimore, Minore, Minores, Minores, and 2 Department of Health a Important: if flem 27 is any injury or other transmission.	21. Signature of Funeral Service Lice 23a. Party Enter the disease, or co	AL S	d the death. I	812	25 Sou	thern MD B		ngs, Ma		,
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a. A.	naple Due to (or as			ympho.	mA-		1	8 months
Geath certificate be assecuted estending physician and dor use as the burial-transit channel.		c	Due to (or as							
Box eath cert attendin for use							L cot Did			
P.O. Box set the death ce d by the attendir seteched for use	Part It. Other eignificant conditions	contributing to death b	iut not resultin	ng in the und	erlying cau	se given in Part I.		Yes 25€No		the cause of death?
								100 40.5010	00110	ably 45 elikiletiii
aw requir								an autopsy med?	COI	ere autopsy findings ailable prior to mpletion of cause death?
The page							10	Yes 🖈 No	10	Yes 2□No
Vital I	25 Was case referred to medical					26. Place of De	eath (Check only	one)		
Of Vita Physician: this certific ral director,		Hospital: 1 Inpation	ent 2 ER	/Outpatient	3□ DOA	Other: 4 Nursing	Home 5□ Resi	dence 8 □Oth	er (Specify	y)
ding Ph After th funeral		28a. Date of Inju (Month, Da	iry 28	b. Time of Injury	28c	Injury et Work? 1 ☐ Yes 2 ☐ No	28d. Describe	how injury occur	red	
Division of Vital Re To the Hospital or Attending Physician: The is within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page Madical Cartification: To Re Com	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of In	jury - At home c. (Specify)	e, farm, stre	et, factory, o	offica	281. Location ( City or To		ber or Rura	ni Route Number,
he Hospitu in 24 hours he Funera pletely fille	29a. Certifier Check only (Check only one)	hyelclan: To the best miner: On the basis o and manner st	f examination	dge, death of and/or inve	occurred at estigation, in	the time, date and place my opinion, death occ	e, and due to the curred at the time,	cause(s) and m date and place,	anner es st and due to	ated. the cause(s)
To the To the Complex	29b. Signature and title of certifier  Muchan	1 Bura	d,	(4)		10 26 287		29d. Date signe		Day, Year)
	30. Name and address of person who	completed cause of	death (Item 23	Ba) (Type, P	rint)			/		
10	Michael Berar					College I	Park Md	20740		
State	21 Date filed (Month Day Voor)	1,	rar's Signature		1.	. Wileye I	CLINY PALE	20/40		
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DHMH 16 Rev 6/95



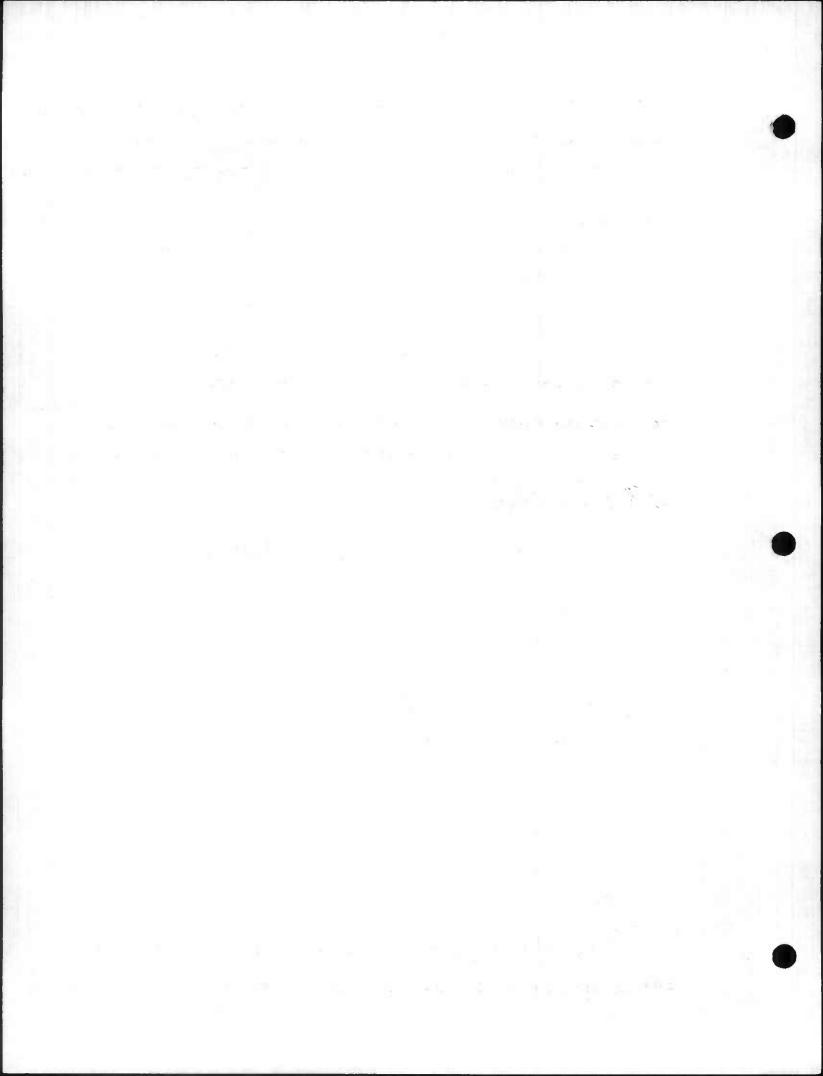
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** MARIA TEODORA BARBEHENN May 4:00 p.m. 1999 12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Solomons Nursing Center Solomons Calvert. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Pay, Year)
June 12, 1935 7. Age (In yrs. lest birthday) **Funeral** Months Days Hours Min. 1□ M 2□F Yrs. The Netherlands 228 56 2724 63 Director Usual Residence of Decedent the Meryland 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Maxical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10073 Breeden Road 20657 USA deeth Funeral 12. Was Decedent Ever In U,S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filled within 72 hours after c Department of Health and Mental Hygiene. Important: if frem 27 is marked other than "natural, or item any injury or other traumatic event, the Medical Exercises once." 1 ☐ Never Married 2 ☐ Married Specify: white Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: g 3 Widowed 4 Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) home maker own home 12 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Hendrikus Gerardus Slakhorst Maria Johana Hostede 19a. Informant's Neme/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 98683 George Henry Barbehenn-son 2609 Southeast Briarwood Dr., Vancouver, Wash. 20b. Place of Disposition (Neme of 20a. Method of Disposition Date 20c. Location - City or Town, State Metropolitan Crematory 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-14-99 Alexandria, VA 21. Signature of Fuperal Septem Licensee 22. Name and Address of Facility Rausch Funeral Home, Owings, MD Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Metastasy /Medical Immediate Cause (Finel Ovarian Carcinoma disease or condition resulting in death) Examiner Due to (or as a consequenca of). buriel-transit that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last pug Due to (or as a consequence of): physician s the buriel P.O. Box 68760. Physician/Medical Due to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 tailme. 1 Yes 2 No 3 Probably 4 Unknown Keller ozutur signed t Records, þ 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed peen completion of cause of death? has 1 ☐ Yes 2 ☐ No certificate Division of Vital Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Be 28. Placa of Deeth (Check only one) axaminer? Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpalient 3 ☐ DOA 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred Certification: After 1 Netural 2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No in by the Director: 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ HomicIde To the Hospital o within 24 hours aft To the Funerei DI completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(a) and manner as stated.

| Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ellmousar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2417 Solomons Isl. Rd. Huntingtown, Md. 20639 ZAhir ZAKIR UOUSAF, 31. Date filed (Month, Dey, Year) M.D. 32. Registrar'a Signature State MAY 1 4 1955 oaks Registrar

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 2:23 AM FRANCES MHO /Medical 4e. Fecitity Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner DOCTOR'S HOSPITAL LANHAM Prince Georges' 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funerai** 1□M 2XF Months Deys Hours 579-34-1652 Director 70 May 21, 1928 Washington, D.C Usual Residence of Decedent 10b. County 10c. City. Town or Location show 10d. Inside City Limits r than "natural", or items 23s or 28a-f short the Middel Examiner naist by notified at 1X Yes 2 No Director Maryland Prince Georges' Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 5815 Sheriff Road 20743 USA Funeral 11 Maritel Stetus 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Rece - American Indian Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 No 1 Yes 2 No Specify: Completed by 3XXWidowed 4 □ Divorced Yeer or Dates: BLACK 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etementery/Secondary (0-12) College (1-4or 5+) 12th Homemaker Self. or other traumatic event, 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be Peges 1 and 2 should be nent of Health end Mentel Moses Porter Blanche Coleman 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Peges 1 and 2 Department of Health e Important: If item 27 is any injury or other tra Charlene Chase/daughter 5815 Sheriff Rd. Capt. Heights, Md. 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 XBuriel 2 ☐ Cremetion 3 ☐ Removet from State Nat'l Harmony Mem.Pk. 5/11/99 4 ☐ Donetion 5 ☐ Other (Specify) Landover .Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Frazier's Funeral Home, Inc. 389 Rhode Island Ave., N.W. Wash., DC 20001 23e. Pert1. Enter the disease, or complications that a used the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse or ech line. Approximete Intervel Between Onset end Deeth **Physiclan** /Medical Immediete Ceuse (Finat Respiratory disease or condition resulting in death) **Examiner** Examiner distres syndrome The law requires that the deeth certificate be executed Sequentielly list conditions, if eny, leeding to transdiate cause. Enter Underlying Ceuse (Disease or Injury that Initieted events resulting in deeth) Last use as the burief-tran P.O. Box 68760, preumor Physician/Medicai Po Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? he 6 1 Yes 2 No 3 Probably 4 Unknown Records, þ 8 24b. Were eutopsy findings evalteble prior to director, page 2 should Completed 24e. Wes en eutopsy performed? completion of cause of deeth? certificate hes 2 No 1 Yes 1 ☐ Yes 2 ☐ No of Vital Physician: Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) exeminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) P L 1 ☐ Yes 2 X No 1 Inpatient 2 □ ER/Outpetient 3 □ DOA this the funeral 27. Menner of Deeth 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how injury occurred After Division or Attending Neturel 5 Pending investigation 1 Yes 2 No To the Hospital or Attendi within 24 hours after deeth. To the Funeral Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) filled in by 4 Homloide Medical 29a. Certifier Cartifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) end manner as stated. | Acatifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, and due to the cause(s) and mainten as stated.

2 Medical Examiner: On the bests of examinetion and/or investigation, in my opinion, death occurred at the time, dete end piece, and due to the cause(s) end menner stated. completely (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) Pinolvan umpuang 2019 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) 7721 BELLE POINT DR GREENBELT Md 20770 PIMOLVARN LIMPUANGTHIP 32. Registrer's Signeture 31. Dete filed (Month, Day, Year) State MAY 1 0 1999 Registrar

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# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

MATLE A. COTIN  MAY 5, 1999 9:15AM  Month of Technology Control, give above and numbers  Suburban Hospital  Social Social Social Manager of Technology Control (1994)  Social Social Social Manager of Technology Control (1994)  The State of Technol	ian	Decedent's Name (First, Middla, Last)					2. Data of Deat Month	Day	Year	. Time of Death
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Social Security Number   S. See   Z. Age (in yrs in the thinky)   Bludger (yet)   If (1006) 24 Hz   S. B. (yet)   S. B. B. (yet)   S. B. (yet)	iner		and number)				ocation of Death	4c. County of	of Death	
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State of Maryland / Department of Health and Mental Hygiene

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Elementary/Secondary (0-12)  12th  Supervisor (Mail)  Supervisor (Mail)  Supervisor (Mail)  Clay Carter  18th Mother's Name (First, Middle, Last)  Clay Carter  19th Informant's Name/Felationship (Type, Print)  Donna Carter (wife)  3420 Weltham Street Suitland, MD 20746  20th Method of Disposition  18th Sturial 2   Cremation of Supervisor (Wail)  20th Method of Disposition (Name of Company (Name of Company), Organization (Name of Company), Org			cify Yes or No-	Hispenic Origin? (Sp	as Decedent of H	U,S. 13.	12. Was Decedent Ever i		11. Marital Status	ne	5
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Elementary/Secondary (0-12)   College (1-4or 5+)   Supervisor (Mail)   Government	stry	Kind of Business/Indu	16b. Kin	pation	nt's Usuai Occup	16a. Dece	ication	15. Decedent's Edu	(Sne	peted	
17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Surname)   19. Mailing Address (Street and Number or Flural Route Number, City or Town, State, Zip Code   3420 Weltham Street Suitland, MD 20746	ense	pt. of Def		d)	NOT use retire	life.		T		du	
17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Surname)					isor (Ma	Super				S	
Care   Care   Ella Revel		en Sumame)						(First, Middle, Last)	17. Father's Name	Be	
Donna Carter (wife)  20e. Method of Disposition 3   Removal from State   20c. Location - City or Town, S   20c. Method of Disposition   3   Detail   2   Dorentation   2   Dorentation   3   Detail   2   Dorentation   3   Dorentation   4					T			-	2		
20e. Method of Disposition 18 Burial 2   Cremation 3   Removal from State 4   Donation 5   Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility 4308 Suitland Road Suitland, MD 20746  Apprinted of the failure. List only one ceuse on each line.  23a. Part1. Enter the disease, or complications that caused tife death. Do not enter the mode of dying, such as cardiac or respiratory errest, interesting in death)  25a. Part in the disease or condition resulting in death)  25a. Part in the disease or conditions of the failure. List only one ceuse on each line.  25a. Part in the disease or condition resulting in death)  25a. Part in the disease or conditions of the failure. List only one ceuse on each line.  25a. Due to (or as a consequence of):  25a. Was case referred to medical events resulting in the underlying cause given in Pert I.  25b. Did tobacco uses contribute to the or death of deat	iode)										
1	n Stete			street sui						-	
21. Signature of Funeral Service Licensee  22. Name and Address of Facility  MARSHALL'S FUNERAL HOME  4308 Suitland Road Suitland, MD 20746  4308 Suitland Road Suitland, MD 20746  Apprinter  Shock, or heart failure. List only one ceuse on each line.  Immediate Cause (Final disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, interest of the conditions of th					tory or other pla	cemetery, cre	Removal from State	Cremation 3 1	1 ₺ Burial 2		
MARSHALL'S FUNERAL HOME  4308 Suitland Road Suitland, MD 20746  23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line.  Immediate Cause (Final diseases or condition resulting in deeth)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Cause (Disease of Injury had in initiated events resulting in deeth) Lest  Due to (or as a consequence of):  23b. Did tobacco use contribute to the or light resulting in deeth) Lest  1   Yes 2   No 3   Probably  24a. Was an autopsy performed?  24b. Were au eveiliable complete	aryland	ltenham, M	5-14 Chelt								. 6.
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line.  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line.  25a. Part II. Other final disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line.  25a. Part II. Other final disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line.  25a. Part II. Other final disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line.  25a. Part II. Other final disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock or shock or shock or shock or heart failure. List only one ceuse on each line.  25a. Part II. Other as a consequence of):  25b. Due to (or as a consequence of):  25c. D				MAI		4	L. Brax	wara	1200	2112	puca
timediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (o	Approximate Interval Between						lications that caused the c	the disease, or comp	23a. Part1. Enter		
Cause (Disease or Injury that initiated events resulting in deeth) Lest  Due to (or as a consequence of):  d.  Part ii. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.  1   Yes 2   No 3   Probably performed?  24a. Was an autopsy performed?  24b. Were au eveileble complete of death  1   Yes 2   No 1   Yes  25. Was case referred to medical examiner?  1   Yes 2   No 1   Yes  25. Was case referred to medical examiner?  1   Yes 2   No 1   Yes  26. Place of Deeth (Check only one)  27. Manner of Deeth  1   Natural   S   Pending investigation   S   No   S		)	(ALS)	CLEROSI	ence of):	(or as a conse	Due t	ion	disease or conditi resulting in deeth)	niner	niner
Part il. Other aignificant condittons contributing to death but not resulting in the underlying cause given in Pert I.    1   Yes 2   No 3   Probebly								immediate derlying	if any, leading to it cause. Enter Und	ÜX.	
Part ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.    1   Yes   2   No   3   Probably					enca of):	or as a conse	C. Due t	ts	that initiated even	dica	
24a. Was an autopsy performed?  24b. Were au eveileble complete complete of death  1   Yes 2   No 1   Yes  25. Was case referred to medical examiner? 10 Yes 2   No 1   Yes  27. Manner of Deeth 1   Anatural   S   Pending investigation   28a. Date of Injury   28b. Time of Injury   28b. Time of Injury   28c. Injury at Work?   1   Yes 2   No 2   N				\			d		Cartilla Chara	Me	
24a. Was an autopsy performed?  24b. Were au eveilleble complete of death  1							M•			al	
24a. Was an autopsy performed?  24b. Were au eveilleble complete of death  1	the cause of death	co uas contributa to t	23b. Did tobacco u	ven in Pert I.	lerlying cause giv	sulting in the	ntributing to death but not	Hicant conditions co	Part il. Other aign	ysic	
24a. Was an autopsy performed?  24b. Were au eveileble completi of death  1   Yes   2   No   1   Yes    25. Was case referred to medical examiner?  15   Yes   2   No   No   No   No    16   Yes   2   No   No   No   No    17   Yes   2   No   No   No   No    18   Nursing Home   SM Residence   6   Other (Specify)	ably 4 Unknow	2□ No 3□ Probe	1 Yes 2								
25. Was case referred to medical examiner?  1 Yes 2 No  1 Inpatient 2 ER/Outpatient 3 DOA  26. Place of Deeth (Check only one)  Check only one)  Check only one)  Check only one)	e autopsy findings		24a. Was an autops								
25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)	pletion of cause	com	perioniled							olet	
25. Was case referred to medical examiner?  1	Yes 2□ No	200 No 1 🗆	1□Yes 20							E	
Other: 4 Nursing Home 5 Residence 6 Other (Specify)				26. Place of Deel				erred to medical			
		6 □Other (Specify)	ne 5 Residenca 6	ner: 4 Nursing Ho	3 DOA Oth	☐ ER/Outpatie	Hospital:	] No		0	
2 Accident investigation 3 Sulcide 6 Could not be determined 4 Homicide 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify)  28f. Location (Street and Number or Rural Round City or Town, State)		jury occurred	28d. Describe how Injury	ry at	28c. Inju	28b. Time	28a. Date of Injury (Month, Dev Yea		. /		
3   Sulcide 4   Homicide   Sulcide 5   Sulcide 6   Sulcide 6   Sulcide 6   Sulcide 7   Sulcide						,	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	investigation	2 Accident	atlo	
	Route Number,				t, factory, offica	home, farm, s cify)	28e. Plece of Injury - Abuilding, etc. (Sp.	dotominad		ertific	
29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) and manner as stated.  29 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated.							nar: On the basis of exan		(Check only		
290. Signature and fille of certifier 29c. License number 29d. Date signed (Month, Day,					29c Licens		10 06	offitie of certifier	29b. Signatur@ay	_	lelely !
	ay, Year)	and placa, and due to t	29d. Date	se number	290. Licens						(10.00
30. Name and eddress of person who completed cause of glooth filtern 23a) (Type, Print)  MAKIO F. GOLUE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND		and placa, and due to to to all places and due to		320-4	230. Extens	1 DAA	MENAN	UIII III	M	1	completely tilled in

SEE A YAT

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month 6:30 pm 99 There FRANKLIN CHANC 12 Heren 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street end number) 4c. County of Death Stone 73 Westmi If Under 24 Hrs. Koad ster Larroll 6. Sex If Under 1 Year Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dey, Year) Min 1 M 2 F Months Deys Hours Yrs. 215.40-0431 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No lestminster arroll 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S. A 14. Rece - American Indian, 3773 tone 21158 Dad 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Status Bleck, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 1 ☐ Never Married 2 ☐ Married 1□ Yes 2 No Specify 3 Widowed 4 □ Divorced White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Coilege (1-4or 5+) Elementary/Secondery (0-12) Home maker Own home 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Benjamin Mary Tranklin Gunther 19b. Meiling Address (Street end Number or Rurel Route Number, City,or Town, Stete, Zip Code) 19e. informent's Neme/Reletionship (Type, Print) Debra triend Hanover 17331 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, State 1 Buriei 2 Cremetion 3 Removei from State 4 ☐ Donetion 5 ☐ Other (Specify) Park Cemetery 5-1599 21. Signature of Funeral Servicer Licenses 22. Name end Address of Facility Pritts Funeral Home and Chapel 412 Washington Road Westminster, oot enter the mode of dying, Such as cardiac or respiratory errest, MD21157 Approximete Intervel Between Onset and Death e, or complications that caused the death. immediate Ceuse (Finel diseese or condition resulting in death) Due to (or es e consequence of): Years Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of) Years Due to (or as e consequence of) 23b. Did tobacco usa contributa to the cause of death? Part II. Other elgnificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 ☐ Yee 2 ☐ No 24b. Were autopsy findings eveilable prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3□ DOA

**Physician** /Medical Examiner

important: If its any injury or oth

**Physician** 

/Medical

Examiner

10a. Stete

Director

Funeral

þ

Completed

Be

To

**Funeral** 

**Director** 

7 is marked other than "naturel", or flems 23s or 28s-f show traumstic event, the Modical Examiner must be notified at

Pagas 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiere.
suit: If items 72 is marked other than "naturel; or items 23 usit; if item of 7 is marked other than "naturel; or items 23 ury or other traumatic event, for Made is a suit or man.

Baltimore, Maryland 21215-0020

with the Maryland

Examiner Physician/Medical 88 use þ Completed Be

physician and the buriel-transit signed by the a d be datached t should certificate has b To this funeral After

that the death certificate be executed Division of Vital Records, P.O. Box 68760, or Attending Physician: Certification: aftar death. Director: Aft hours a 24 hours

1 Yes 2 No 27 Manner of Deeth 1 Naturel 2 Accident 3 ☐ Suicide 4 | Homicide

29a. Certifier

5 Pending Investigation

6 Could not be determined

28a. Dete of tnjury (Month, Dey Year)

28e. Pieca of injury - At home, ferm, street, factory, office building, etc. (Specify)

28h Time of

28c. Injury et Work? 1 Yes 2 No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

laney four,

28d. Describe how injury occurred

15 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of cartifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

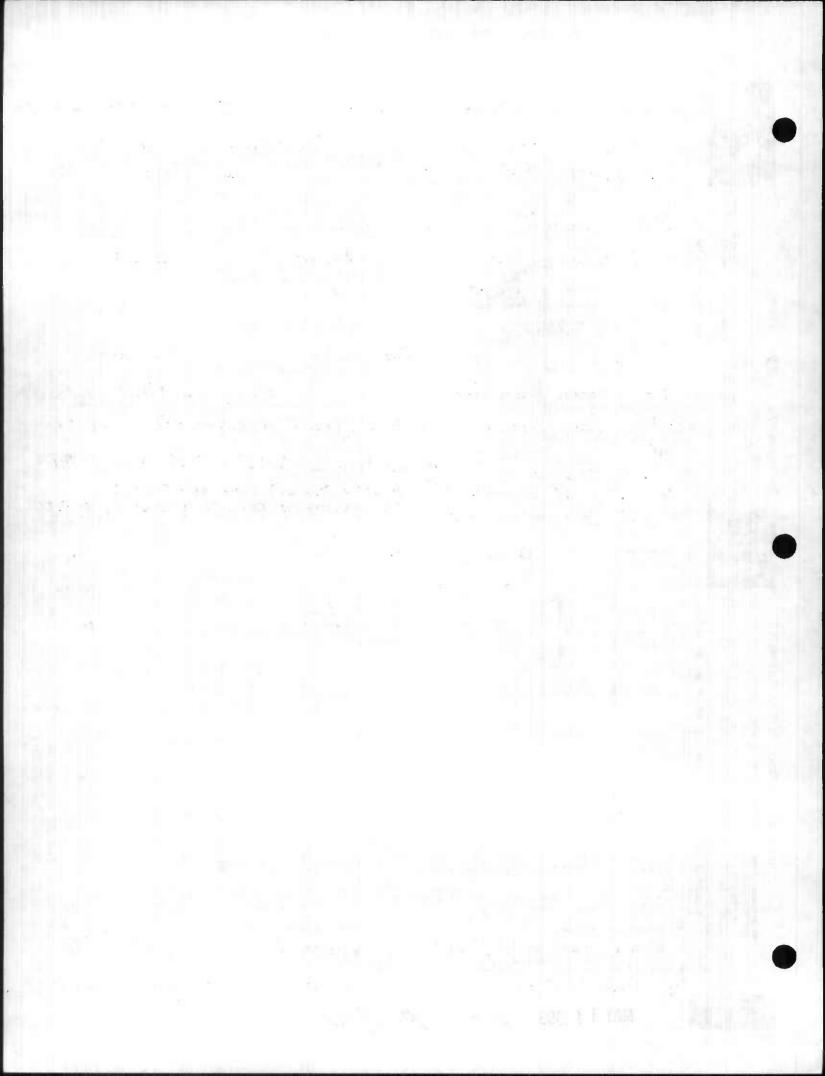
Dr. Wenifredo Iglesia 31. Dete filed (Month, Day, Year) MAY 1 4 1999

32. Registrar's Signeture

State Registrar

Medical

To the Hosp within 24 hos To the Fune completely fi

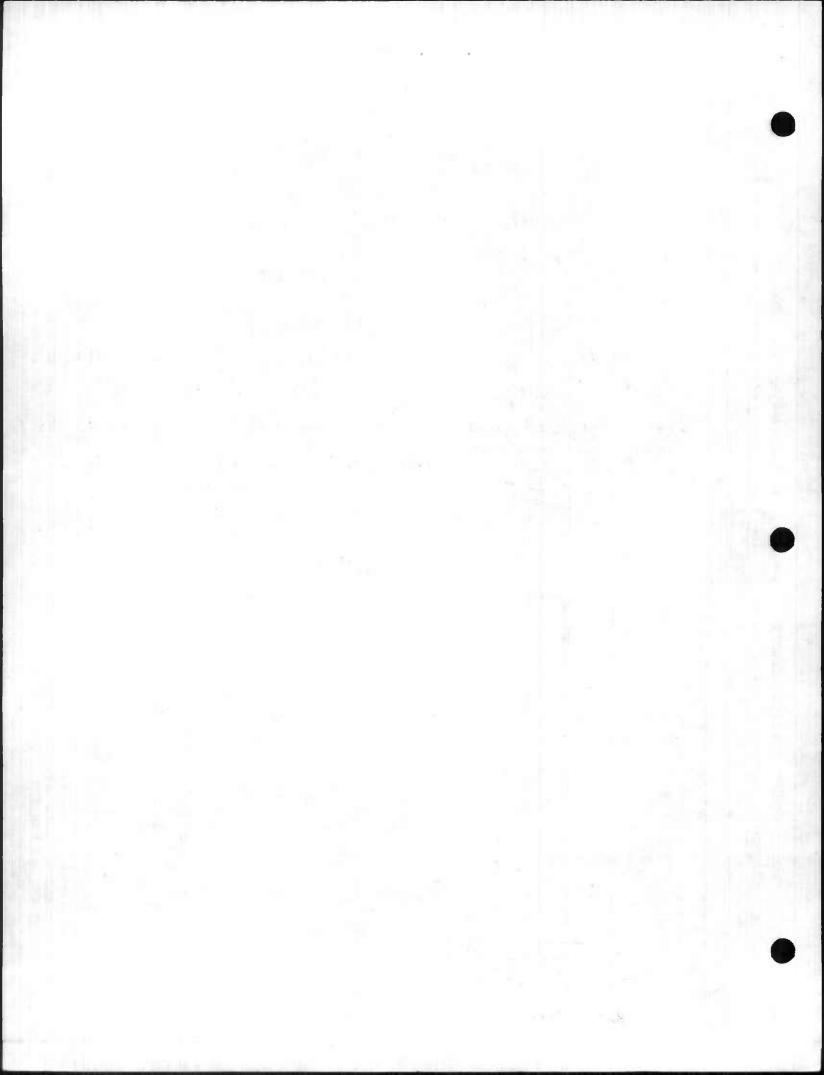


99-2751-510 crn Madeline M. Copes

Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

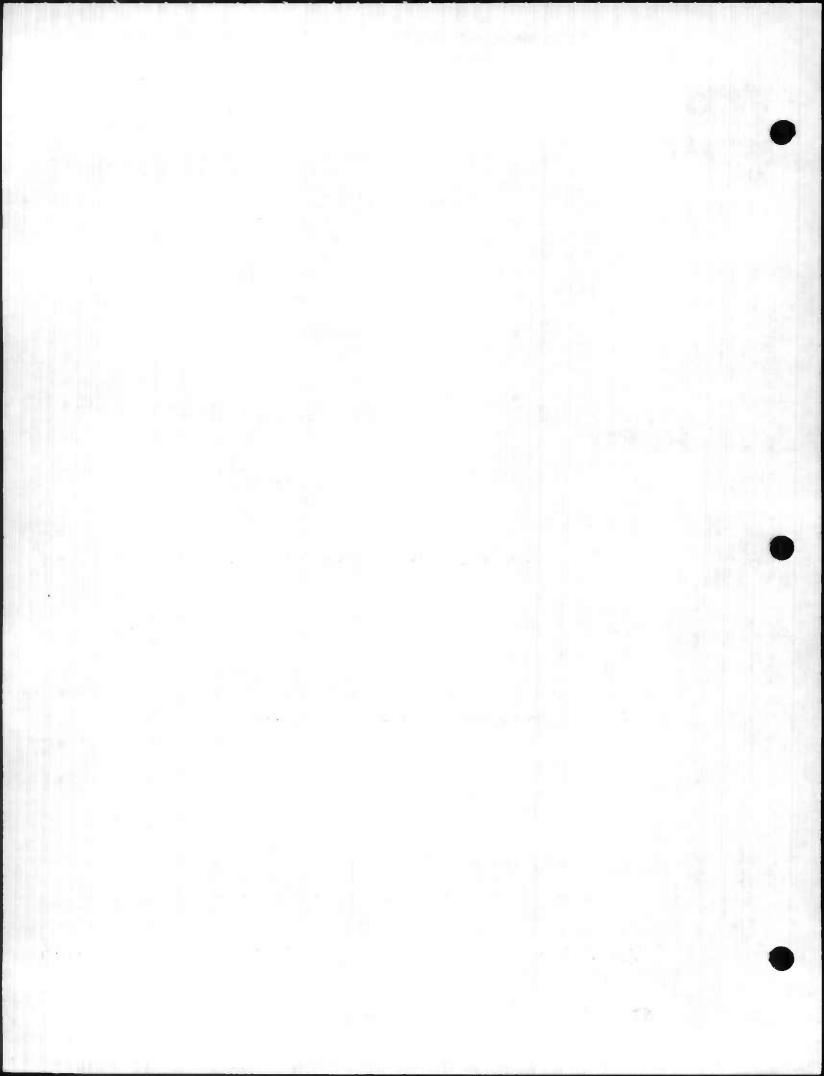
0.2.2.1.0 11. 00	PCS	Certificate of Death	Reg. No.	17193
State I along	1. Decedent's Nama (First, Middle, Last)		2. Data of Death Month Day	3. Time of Death
Physician /Medical	Madeline M.	Copes	May 12, 1999	11:05 P.M
Examiner	4a Facility Nama (If not institution, give street and number)	4b. City, Town, or I		
	University of Maryland, Shock Tr			A
Funeral Director	5. Social Security Number    Social Security Number   6. Sax   7. Aga (In yrs. last   7. Mga (In yrs. last   7. Mg	t birthday) If Under 1 Year If Under 24 Hrs.  Workths Days Hours Min.	8. Data of Birth (Month, Day, Year) 9-1-22	9. Birthplace (Stata or Foreign Country)
Maryland la-f show iffied at	1111	Fown or Location  K Hall		10d. Inside City Limits
th with the Ma 23s or 28s-f s unt be notified rai Director		101. Zip Code 23 4 ( 6	10g. Citizen of Wh	at Country?
020  wur after Geeth v sir, or Items 23s  Examiner mast  by Funeral	3 Widowed 4 □ Divorced If Yas, Giva Yaar or Datas:	13. Was Decedent of Hispanic Origin? (S If Yas, specify Cuban, Mexican, Puert  1 Yas 2 No Specify:		American Indian, Whita, atc.
5-0 72 ho	15. Decedant's Education (Specify only highast grade completed)	16a. Decedent's Usual Occupation (Giva kind of work done during most of wor	16b. Kind of Bus	ness/Industry
d 21215-0020 ited within 72 hours at hydisten. her than "natural", on ht. the Medical Exam Completed by I	Elamentary/Secondary (0-12) Collega (1-4or 5+)  Ohn Grade  17. Fathar's Name (First, Middla, Last)	Sales lady	na (First, Middle, Maiden Sumama	INC,
Be Be		l i	R - 1   Sumama,	
Maryland 12 should be file 12 should be file 1 is marked othe traumatic event To Be (		19b. Mailing Addrass (Street and Number or Ru	Drittingh	Com. Zin Codal
Saltimore, Ms amit. Page 1 sod 2. operiment of Heath, a reportant if lien 27 is ny injury or other tras	Grace Bagwell gradaught	1529 Mathavia // De of Disposition (Nama of atary, crematory or other place)	Data 20c. Location - C	ity or Town, State
Balti permit. Departi Importa any inja	21. Signatura of Funaral Sarvice Licensee	> 22. Nama and Address of Facility / BCM/C Smith Tun	eral Home	212185
	23a. Part I. Entar the disease or complications that caused the death, shock, or heart tallers. List only one cause on each line.		or raspiratory arrest,	Approximata Intarval Between
Physician /Medical Examiner	Dua to (or a:	s of abdominal injurions a consequence of):	es	Onset and Death
58760, icate be associted physician and at the burist-transit sub-burist-transit section Examiner		s a consequence of):		
E 04 5	that initiated evants rasulting in death) Last Dua to (or as	s a consequence of):		
death cer death cer he attendir ed for use	Part II. Other significant conditions contributing to death but not resulting	ng in tha undarlying cause given in Part I.	23b. Did tobacco use cont	ribute to the cause of death?
that the deserted by the a detached by Physic	Hypertensive Arteriosclerotic Ca	rdiovascular Disease	1 ☐ Yes 2 💢 No :	B Probably 4 Unknown
cords requires been sign should be	Diabetes Mellitus		24a. Was an autopsy performed?	24b. Ware sutopsy tindings available prior to completion of cause of death?
I Recomp			Approval XNo	1 ☐ Yes 2 ☐ No
Vital I		26 Place of Des	ath (Check only one)	10103 2010
	axaminar? 1 ☑ Yas 2 ☐ No Hospital: 1☑ Inpatiant 2 ☐ ER	Other	loma 5 ☐ Rasidence 6 ☐ Othar	(Specify)
Division of To the Hospital or Attending Phywithin 24 hours after deeth. To the Funeral Director: After this completely filled in by the funeral director Medical Certification: To		8b. Tima ot Injury at Work? 1:15 P M 1 □ Yas 2 ⋈ No a, farm, street, tactory, office	28d. Describe how Injury occurre motor vehicle of another motor v. 28f. Location (Street and Number City or Town, State)	ollided with ehicle. For Rural Routa Number, 679 @ Rt. 703
he Hospital in 24 hours he Funeral pletely filled edical C	29a. Cartifiar (Check only one)  1 Certifying Physician: To tha best of my knowle (Check only one)  Medical Examiner: On tha basis of axamination and mannar stated.			ner as stated.
No the complex of the	26c. Signaliste and It a of certifiar	29c. License number	29d. Data signed	(Month, Day, Year)
	M.D. M.D	O.C.M.E.	May 13,	1999
3	30. Name and address of person who completed cause of death (Item 23	Ba) (Type, Print)  111 Penn Street, I	Baltimore, Marvl	and 21201
State Registrar	31. Data filed (Month, Day, Year)  MAY 1 8 1999  32. Registrar's Signature	_		



State of Maryland / Department of Health and Mental Hygiene

Physician /Medical		Name (First, Middle,			0	. 4. 4		2. Date of De Month May	ath 16, Day 199	Year 3. Tim	e of Death
	Iona	an Africa Institution	Mae	h and	Cuppe	ett	4b. City, Town, or				)Oam
Examiner		ne (If not institution, gany Coun			ome		Cumberl	and		Allegar	ny
Funeral Director		2-9714	. Sex 1□ M 2⊋ F	7. Age (In yrs.	. last birthdey) 7 Yrs.	If Under 1	Year If Under 24 Hr. Pays Hours Min	8. Dete of Bir Aug 2.	year 1901	9. Birthplace (Sta	te or Foreig
M 10	Usuel Residence 10a. State	10b. County		10c. Ci	ity, Town or Lo	cation				10d. inside	e City Limits
28a-f show notified at rector	MD	All	egany		Cur	nberla	and			120	Yes 2□No
0 0	10e. Street and 422 V	Number i <b>rginia</b>	Avenue			10f. Zip C	21502		10g. Citizen of V USA	Whet Country?	
natural, or items 23		us Married 2⊡ Married ed X⊡ Divorced	12. Wes Dece Armed For 1 Tyes If Yes, Giv. Yeer or Da	ces? 2 ⊡No		Ves Deceder f Yes, specify	t of Hispenic Origin? ( Cuban, Mexican, Pue No Specify:	Specify Yes or No to Rican, etc.)		a - American Indiar ck, White, etc. "white	n,
di di		15. Decedent's Specify only highest ( Secondary (0-12)	Education grade completed) College (1	4or 5+)	-	dent's Usual C kind of work DO NOT use naker	Occupation done during most of wo ratired)		16b. Kind of Bu	usiness/Industry	
if of Haalth and Mental Hygiena.  If Item 27 is marked other than or other traumatic evant, tra Ma		me (First, Middle, La 5 Kerns	st)				18. Mother's Na Albert	me (First, Middle,		ne)	
ls ma	19a. informent	's Name/Relationship S V. Sim	(Type, Print)		19b. Mailii P . O .	Box 9	itreet and Number or F	ural Route Numb	er, City or Town, 26726	Stete, Zip Code)	
or other tr		2 Cremetion 3			Place of Dispo cametery, cres	sition (Name natory or othe	of or placa)	Date		City or Town, Stele	9
Departmant of Haalth Important: If Item 27 any Injury or other ti DDCB.		on 5 Other (Spe		01		starpe	ery Tri Fune land, Ma	ral Hor	Oldtowne P.A. 21502		
	23e. Part1. En shock, or	ter the disease, or co heart failure. List on	omplications that cally one cause on ea	used the dee			f dying, such as cardie	-		Approxi	mate Between
nysician Medical xaminer	Immediate Cau disease or con resulting in dea	dition	a. CAHLO		OBST1		IE LUNG	DISE	7-55		ML),
physician and is the burial-transit	Sequentially lis	et conditions.	b	Due to (	or es a consec	uenca of):					
physician and s tha burial-transit edical Examir	Sequentially lis if eny, leading cause. Enter U Cause (Disease that Initiated ev	to immediate Indertying e or injury	C							İ	
	thet initieted ev resulting in dee	rents oth) Lasi	d	Due to (	or as a consec	uence of):			-4		
e attandir d for use	Port li Other al	gnificant conditions	contributing to de	ath but not rec	sulting in the u	nderlying cau	se given in Part I	23b Did	tobacco usa co	ntributa to the cau	es of death
signed by the attandin d be datached for use d by Physician/N	CHR		CONSES				FAILURG	_ 10	Yes 2 No		4 Unknow
been sign should be leted by									an autopsy ormed?	24b. Were autop evallable pr completion of death?	rior to
S S De								10	Yes 2 No	1 ☐ Yes	20 No
sta has be page 2 sho							1	ath (Check only	one)		
page 2 s	25. Was case r examiner?	eferred to medical	Manaital		ER/Outpaties			Home 5 Resi	dence 6 Oth		
his certification of director	examiner?	21 <b>50</b> No			Ook Time				now injury occur	THO	
After this certification funaral director	examiner? 1 Yes  27. Manner of D Netural 2 Accide	Deeth  5 Pending investigat  6 Could no	28e. Date of (Month	Injury , Dey Year)	28b. Time o	М	Injury et Work? ↑ Yes 2 No		Street and Numb		Number
After this certification funaral director	examiner? 1  Yes  27. Manner of E 1  SNetural 2  Accide 3  Suicide 4  Homici	2 SNo Deeth 5 Pending investigat a 6 Could no determine	28e. Date of (Month)	f Injury , Dey Year) of Injury - At h g, etc. (Speci	Injury nome, farm, str	M eet, factory, o	1 ☐ Yes 2 ☐ No	28f. Location (	wn, State)	per or Rural Route I	Num <i>ber,</i>
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rs after death.  al Director: After this certificated in by the funeral director  Certification: To Be	examiner? 1 Yes  27. Manner of I 1 Several 2 Accide 3 Suicide 4 Homici  29a. Certifier (Check only one)	2 SNo  Deeth  5 Pending investigat  6 Could no determine	28e. Date of (Month) to be ad 28e. Place buildin  Physician: To the baminer: On the ba	f Injury , Dey Year) of Injury - At h g, etc. (Speci	nome, farm, str	M eet, factory, o	1 ☐ Yes 2 ☐ No  ffica  the time, date and place	28f. Location ( City or To	cause(s) and ma date and place,	per or Rural Route I	se(s)
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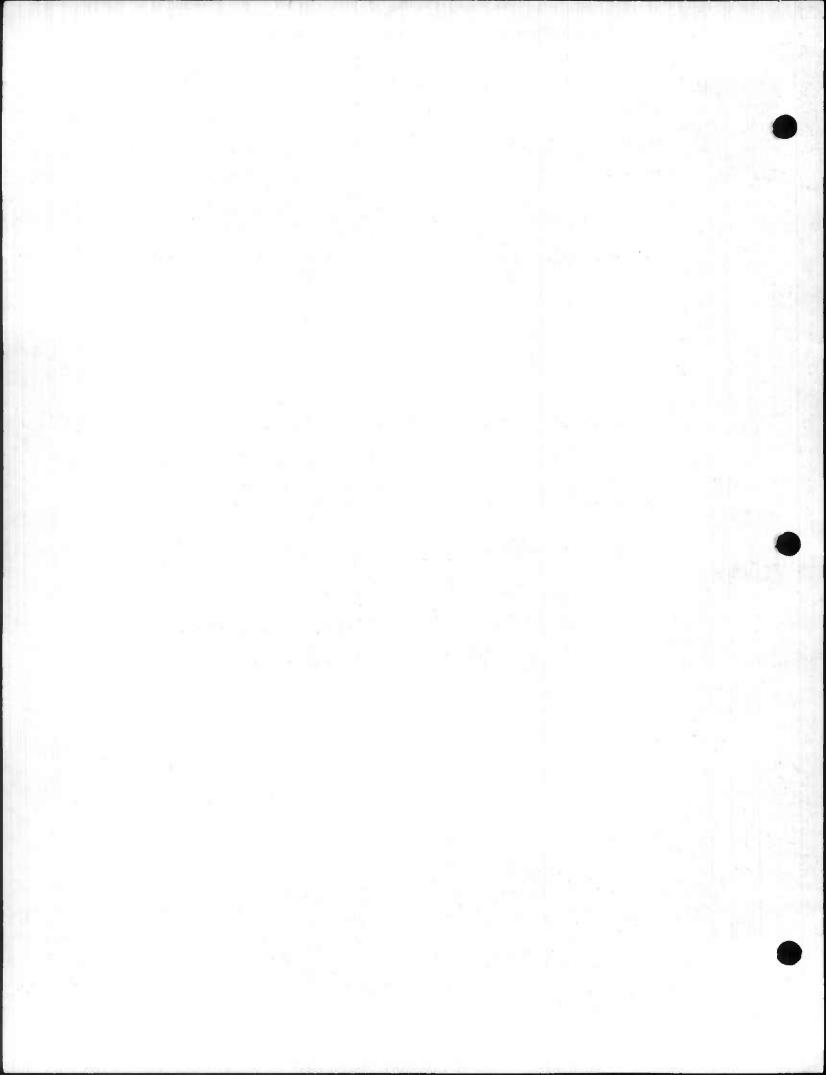
DHMH 16 Rav 6/95



State of Maryland / Department of Health and Mental Hygiene

							Certific	ate of	Death		Reg. No.	2	
			1. Decedant's Nama (First, Middla, I	.ast)						2. Data of De	eath	Ven	3. Time of Death
	Physic /Medi		Ralph Cal	dwell						May	Day	Yaar 1990	8:20 AM
	Exami		4a. Facility Nama (If not Institution, g		)				4b. City, Town, or L			nty of Death	7-0-20-AN
	Funeral Director		Citizens Nurs 5. Social Sacurity Number 6 163-18-9904		ga (In yrs.		hday) If Un Mont	dar 1 Yaar hs Days	If Undar 24 Hrs.	e Grace 8. Data of Bi (Month, Do Jan. 1	rth ay, Year)	rford 9. Birth Cour Virgi	placa (Stata or Foreign
			Usual Rasidence of Decedant			-				puri.	1714	virgi	.III.d
	how		10a. Stata 10b. County		10c. Cit	ty, Town	or Location					1	Od. Insida City Limits
	Sa-I	octo	MD Harf	ord	Hav	re o	de Gra	ce					1⊠ Yas 2□ No
	23e or 2	ral Director	10e. Street and Number 200 N. Washingt				10f.	Zip Coda 2107	8		10g. Citizan d		itry?
0700	72 hours after death with the Maryland "naturel", or items 23a or 28a-f show idical Exameter must be notified at	by Funeral	11. Marital Status  1 □ Navar Married 3 □ Widowad 4 □ Divorced	12. Was Decedant Armed Forcas  1  Yas 2  If Yas, Giva Yaar or Datas:	?	,S.			dispanic Origin? (Spen, Maxican, Puarto Specify:	pecify Yas or No Rican, atc.)	Spec	ace - Amaric lack, Whita, city: Whi	etc.
ה	"natur	ted	15. Decedent's (Spacify only highast of	Education		16a.	Decedant's U	sual Occup	pation during most of work	kina	16b. Kind of	Businass/in	dustry
7700-61717	d within jiene. r than	Completed	Elamentary/Secondary (0-12)	Collaga (1-4or	5+)		Labore	Tusa ratire	d)		Jani	toral	
	0 = 0 5	Bec	17. Fathar's Nama (First, Middla, La	st)					18. Mothar's Nam	a (First, Middle	, Maiden Sum	a <i>ma)</i>	
mai yiaiid		ToE	UNK							NK			
3	and and in m		19a. Informant's Name/Relationship			19b.	Mailing Addr	ass (Street	and Number or Ru	rai Route Numb	er, City or Tow	vn, Stata, Zip	Code) 21078
	ロースト		Janet H. Caldwe	LI (Spouse)		20	10 N. 1	Washi	ngton St.	Apt.	105, Ha	avre d	e Grace, MD
Dailling's			20a. Mathod of Disposition  1 Burial 2 Cramation 3  4 Donation 5 Other (Spec			ematary	Disposition (in crematory of Ferris	or othar pla	ce)	Data 5/18/99	West (		
Dai	permit. Pages Department of Important: If I any Injury or		21. Signature of Funeral Service Lic	R Car			Tar	cring	ess of Facility -Cargo Fu n, Maryla		ome, P.		
			23a Part Enter tha disaasa, or co shock, or haart failura. List on	mplications that cause	tha deat	h. Don	ot antar tha n	noda of dyi	ng, such as cardiac	or raspiratory a	rrest,		Approximate Intarval Between
	Physician /Medicai Examiner		Immadiata Causa (Final disaasa or condition resulting in daath)	Arter	tos	rle	role	00		vasa			Oncet and Death
600000000000000000000000000000000000000	eath certificate be executed attending physician and for use as the burial-transit	lan/Medical Examiner	Sequantially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated avants rasulting in death) Last	. Ren Cong	Due to (o	r as a co	ensequence de la companya de la comp	un Lege	e of for	arlei	Ne		
•	y the	Physici	Part II. Other significant conditions	contributing to death b	out not res	ulting In	tha undarlyin	g causa gi	ven in Part i.		tobacco use o	/	the cause of death?
	\$ 8 B	by F											
vital Hoool 43,	e law requir has been s ge 2 should	Completed				-				perfe	an autopsy ormed?	co of	ara autopsy findings allable prior to mpiation of cause death?
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		o Be	25. Was casa rafarred to rhedical axaminar?  1 \sum Yas 2 \sum No	Hospital:		FD.S		DO: Ott	26. Place of Oaa			NI 17	
	Phys rthis aral d	-	27. Manner of Death	1 Inpatie		ER/Out		DOA	4 Narsing H	oma 5 Rasi 28d. Describe	how Injury occ		r)
	it or Attending P safer death. Director: After t d in by the funera	cation	1 Natural 5 Panding 2 Accident Invastigati 3 Suicide 6 Could not	(Month, Da	y Year)		jury M	28c. Inju Wo 1 □	rk?  Yas 2□No				
	itat or At ins after of al Direct led in by	Certification:	4 ☐ Homicide datamine	d 28a. Place of In building, at	jury - At he c. (Specif	oma, fari y)	m, streat, fac	tory, office		28f. Location ( City or To	(Straat and Nur wn, Stata)	mber or Rura	il Routa Number,
	To the Hospitat or Att within 24 hours after of To the Funeral Direct completely filled in by	edicai	29a. Certifiar 1 Certifying F 2 Medical Exc	hyalcian: To the best iminer: On the basis o and mannar st	f examina	wledga, tion and	daath occurr or Investigat	ed at the til ion, In my d	me, date and place, opinion, daath occur	and dua to tha red at the time,	causa(s) and date and place	mannar as si e, and dua to	atad. tha cause(s)
	To the To the Comple	W	29b. Signatura and title of cartifiar	~		M	D	29c. Licens	se number 2066	514	May.	ned (Month,	Day, Year)
	M	,	30. Name and addrass of person wh	completed causa of c	daath (Itan	( 1,23a) (1	ype, Print)	0	1	~	1, (	1	1
			NTI LIE	611.10	, 1	1	Y AD	MAPI	Mous	ST	HUM	100	5mar
	Sta	te	31. Batis filed (Month, Day Yard Q!	2 Registr	ars Signa	ture	17		mont?	) V	NI	10.5	21070

DHMH 16 Rev 6/95



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Day Month 999 Juna arson Eleanor 1A 4a Facility Nama (If not Institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death BA HIMORE, C (+Y) If Under 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, Year) 7. Aga (In yrs. last birthday) 5. Social Security Number Johns HOPKINS If Undar 1 Yaar Birthplaca (Stata or Foreign Country) PA Months Days 1□ M 2▼ F 75 05/26/1923 196-16-1956 10c. City. Town or Location 10d. insida City Limits 10b. County 1 Yas 2 No Harford Havre de Grace 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 670 Congress Avenue USA 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No if Yas, Giva Yaar or Datas: 14. Race - American Indian, Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Ricen, atc.) Black, Whita, atc. 1 Navar Marriad 2 Married 1 Yas 2 XNo Specify: 3 Widowed 4 Divorced White 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) Elamantary/Secondary (0-12) Collega (1-4or 5+) 12th Homemaker Home 17. Fether's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) **Howard Grant Shafer** Pearl Woodling 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informent's Name/Ralationship (Type, Print) 970 Chesapeake Dr., Havre de Grace, MD 21078 James Carson- Husband 20a. Method of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Removal from State 4 ☐ Donation 5 ☐ Othar (Spacify) Bel Air Memorial Gardens 5/12/99 Bel Air, MD 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Mitchell-Smith Funeral Home, P.A. 23e. Per 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Approximate Approximata Interval Batween Onsat and Death Immediate Cause (Final disaase or condition resulting in daath) Duodenal Cancer Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown sease

**Physician** /Medical Examiner

physician and s the burial-transit

for use as

signed by the et d be deteched for

page 2

director

funeral

filled in by the

certificate

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica

24 hours

To the Hosp within 24 hou To the Fune completely fi

that the death certificete be execu

Division of Vital Records, P.O. Box 68760

Department of Important: If any injury or page.

**Physician** 

/Medical

**Examiner** 

10a. Stata

Directo

Funeral

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Completed

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Examiner

Physician/Medicai

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**Funeral** 

Director

r than "natural", or items 23a or 28a-f ahow the Medical Examiner must be notified at

the Meryler

death

filed within 72 hours effer

I Hygiene.

.. Pages 1 and 2 should be filled wi ment of Health end Mental Hygien tant: If item 27 is marked other th jury or other traumatic evant, the

Baltimore, Maryland 21215-0020

Sequentially list conditions, if any, laading to Immadiate ceusa. Enter Underlying Causa (Disease or Injury that Initiated avants rasulting in death) Last

25. Wes casa referred to medical examinar?

111000

1 Yas 2 No

27. Mannar of Death

24a. Wes an autopsy

24b. Wara autopsy findings availabla prior to complation of ceusa of death?

1 Yas 2000 28. Place of Death (Check only ona)

1 ☐ Yes 2

Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 28d. Describe how Injury occurred

28c. Injury at Work? 28e. Date of Injury (Month, Day Yaar) 2 Accidant 5 Pending Investigation 3 Suicida 6 Could not be datarmined 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida

28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)

1 Certifying Physicien: To the best of my knowledge, daeth occurred at the time, date and place, and due to the cause(s) end mennar as stated.

2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a, Cartifian

29b. Signature and its 29c. Licansa number

Hospital: 1 Preatiant 2 ER/Outpatient 3 DOA

28b. Tima of

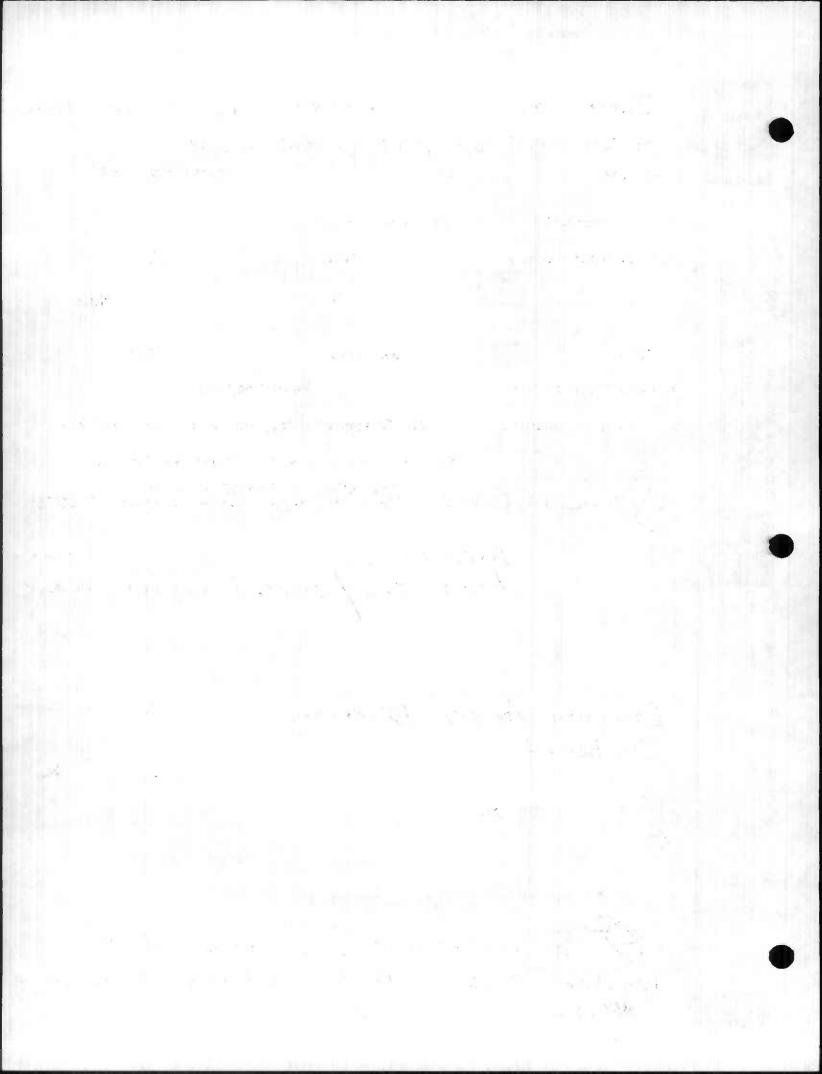
29d. Data signed (Month, Day, Yaar)

30. Name and address of parson who completed Raad, Perryhall MD 21128 hala eather hill 31. Dete filed (Month, onth, Day, Year)

1 Yes

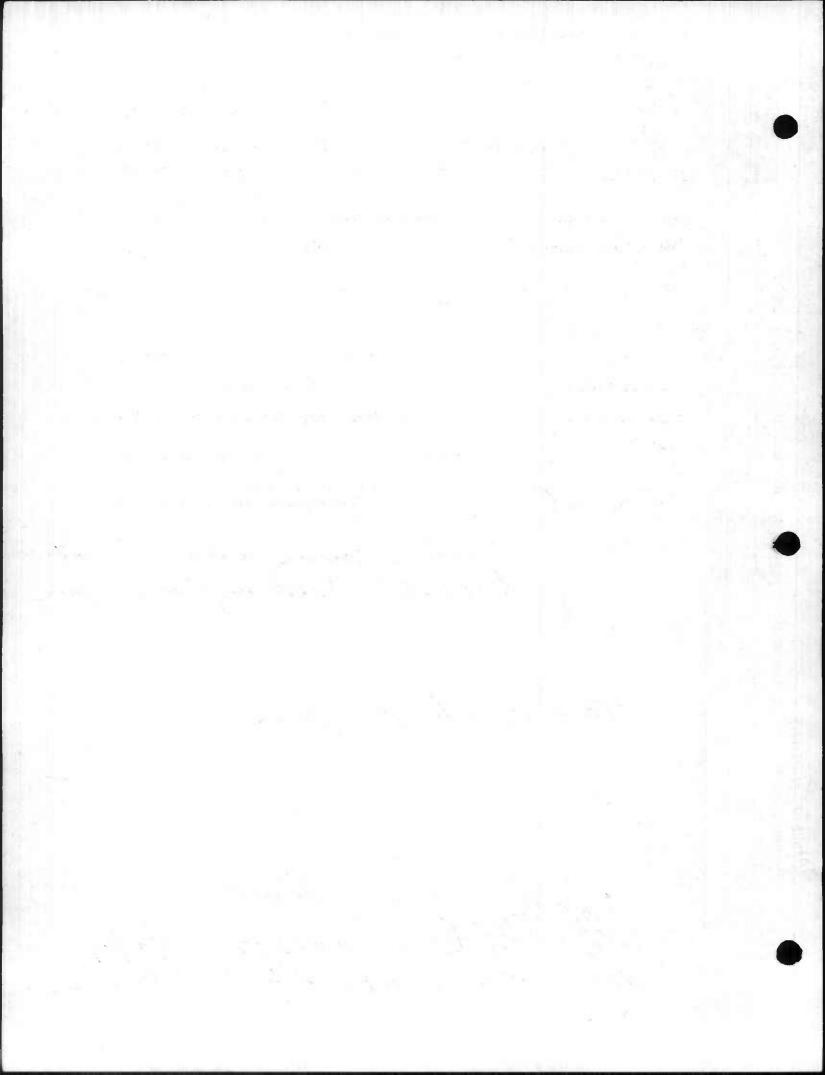
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State Registrar 32. Ragistrer's Signetura



State of Maryland / Department of Health and Mental Hygiene

Physic		1. Decedent's Ner	ne (First, Middle, La:	st)			ate of		2. Dete of D	Reg. No.		3. Time of Death
			B. Chris	,					Month	Dey	Yeer	
/Medi				e street end number)				4h City Town	April or Location of Dee			1:15 P
Exami	ner	Citiz	ens Nur	sing Hom				Havre	de Grac	e Har	ford	
Funeral Director		5. Social Security I 217 24 5. Usual Residence	324	ex 7. Age X M 2□ F	69	Yrs. If Uno Month	hs Deys		8. Date of B (Month, D Mar •	irth Year) 20 1930	9. Birthp	elece (State or Fore ntry)
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T T	to	MD	Harford		На	avre de (	Grace					1 Yes 2 1
23a or 28	ai Director	10e. Street end Nu 369 Wil	son Stree	t		10f. i	Zip Code 21	078		10g. Citizen of U	Whet Coun	ntry?
min 72 mous enter deaun with the imaryand 2. "natural", or thema 23a or 28a-f show Medical Examiner must be notified at	by Funeral	11. Meritel Status 1 ☒ Never Mar 3 ☐ Widowed	ried 2 Married	12. Wes Decedent E Armed Forces? 1 1 Yes 2 □ N If Yes, Give Yeer or Detes:				Hispanic Orlgin? en, Mexicen, Pu Specify:	(Specify Yes or Nerto Rican, etc.)	o- 14. Rec Ble Specif	ck, White, y: BLA	etc.
Hygiene. ther than "naturent, for the first of the first	Completed	Elementary/Sec		lucetion de completed) College (1-4or 5-	+)	6e. Decedent's U (Give kind of life. DO NOT		petion during most of w d)	vorking	16b. Kind of B		dustry
tal Hygie d other event, II		17. Father's Neme	(First, Middle, Last)			Custod	Tan	18 Mother's N	leme (First, Middle			
a d d	To Be		Christy					Eliza		s, meidell Samer	110)	
h end	T		ieme/Reletionship (	Type, Print)					Rural Route Nume ad, Pike			
nent of Health int: If itsm 27 I				Removal from State	ceme	of Disposition (A etery, cremetory of ison Cem	or other pla	ce)	Dete 5/6/99	20c. Location Owings		
Department of Important: If any Injury or once.		21. Signature of Fi	uneral Service Licen	see		Bear	rd Fu	ess of Fecility Ineral H	ome Havre d			
/Medical ixaminer	5	Immediete Cause disease or condition resulting in death)	on	. (1	mall.							
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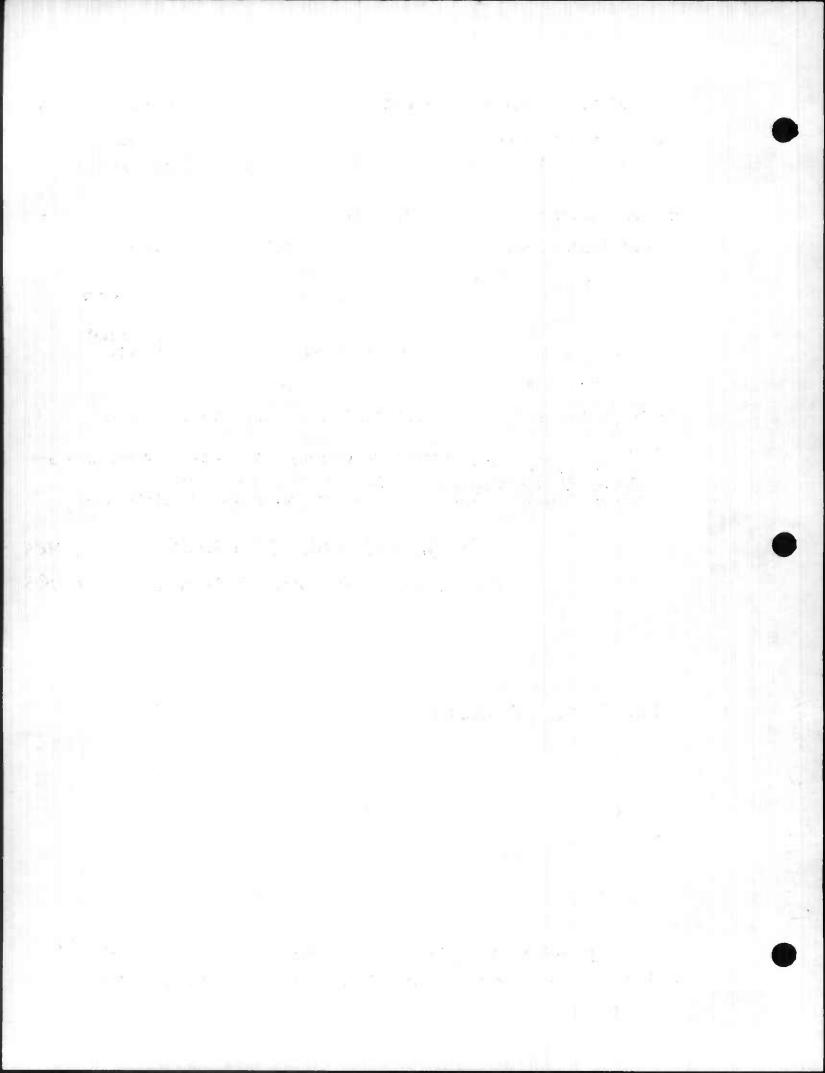
State of Maryland / Department of Health and Mental Hygiene

			Certificate of Death Reg. No.										
			1. Decedent'a Name (First, Middle, La	st)					2. Date of Dea Month		Yeer	3. Time of Death	
	Physici /Medi		Luedema Harrie	tt Cox					May 16,		1991	11:30 PM	
	Examir		4a. Facility Neme (If not Institution, give street and number)					4b. City, Town, or Location of Deeth 4c. County of Death					
			Calvert Manor Nursing Home Rising Sun Cec.								il		
Baltimore, Maryland 21215-0020	Funeral Director	il Director	5. Social Security Number 408-34-9423 6. Sex 1 Months 1 Months 1 Months 1					If Under 24 Hrs Hours Min.					
	and and		Usual Residenca of Decedent  10a. State 10b. County	1	Oc. City, Town	n or Location					T	10d. inaide City Limits	
	Maryl 4 sho									1 ☐ Yes <b>2</b> ☐ No			
	Thought The		Maryland Cecil  10e. Street and Number		Rising		Zip Code			10g. Citizen of V	/hat Cou	ntry?	
	3 with		1881 Telegraph Road 2191					1		USA			
	deeth	Funerai	11 Marital Status 12. Was Decedent Evi		er In U,S.	13. Wes De	cedent of I-	lispanic Origin? (S	specify Yes or No-	No- 14. Race - American Indian,			
	permit. Peges 1 and 2 should be tiled within 72 hours after deeth with the Maryland Depertment of Heelth and Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show ship injury or other traumatic avant, the Medical Examiner must be notified at ance.	To Be Completed by Fu	1 Never Married 2 Married 320 Widowed 4 Divorced	If Yes Give				an, Mexican, Puèri Specify:	to Hican, etc.)	Black, White, etc.  Specify: White			
	72 ho		15. Decedent's Ed (Specify only highest gra	ducation	16a.	Decedent's U	sual Occup	e during most of working		16b. Kind of Business/Indu		dustry	
	ithin		Elementary/Secondary (0-12)	College (1-4or 5+)		'life. DO NOT use retire		ed)					
	ygien rt. the		8		Но	Iomemaker			Own I				
	M of H		17. Father's Name (First, Middle, Last)  James R. Minnick						ne (First, Middle, Malden Surname)				
	Mer Marke Marke									nk) Mann			
	12 sh h and h and r ie m		19e. Informent's Neme/Reletionship (Type, Print)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z							
	1 and Heelt Im 27		Mary Poole/ Daugh 20e. Method of Disposition		20b. Place of	29 Old	Cono	wingo Rd	., Conow:	ingo, Ma 20c. Location		and 21918	
	Pages nent of h int: If its ury or of		NBurial 2 ☐ Cremation 3 ☐	Removal from State	cemeter	y, crematory	or other pla	/	5-19-99				
	it. P.		4 □ Donation 5 □ Other (Specify) Dulaney Val							Timonium			
	Depe Impo		22. Name and Address of Facility Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 210										
	Physician /Medical Examiner		23a. Part 1. Enter merdianase, or com shock, or hand failure. List only	plications that caused th	e death. Do n	not enter the n	node of dyle	ng, such as cardia	c or respiratory ar	rest,		Approximate interval Between	
9			Onset and Death								Onset and Death		
			Immediate Cause (Final disease or condition resulting in deeth)  Due to (or as a consequence of):										
		<u>_</u>											
Division of Vital Records, P.O. Box 68760,	ted nsit	Examiner		b	Due to (or es a consequence of):								
	icate be executed physician and s the bunal-transit	xar	Sequentially list conditions, if any, leading to immediate	Du									
	slciau		cause. Enter Underlying Cause (Disease or Injury that initiated events										
	rtificate be executed ng physician and s as the bunal-transit	Wedical	resulting in death) Last					59 OI).					
	D ig												
	0 0 0	sicie	Part II. Other significant conditions contributing to death but not resulting in the underlying cause					given in Pert i. 23b. Did tobacco use contribute to the cause of death				o the cause of death?	
	by th	Physician/	ASPUI)	_	- KRITIBLE bould			101	1 Yes 2 No 3 Probably Unknown				
		by F	No. C at a see 1					mnu	2				
	law requires as been sign 2 should be	Completed							24a. Was a perfor	an autopsy 24b. Were eutopsy fir available prior to		/allable prior to	
	as be	pie									completion of cause of death?		
	The ate h	Con	187144510N						101	00 2 No	- 1	1 Yes 2 1/80	
	Physician: The lav this certificate has ral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:			- 12.		e of Death (Check only one)				
	Physic this car	Certification: To	1□Yes NO	Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)									
	To the Hospital or Attanding Physician: The i within 24 hours eiter death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page		27. Manner of Death  1 SNaturai 5 ☐ Pending	(Month, Day Y	(Month, Day Year) Injury Work?					Bd. Describe how injury occurred			
			2 Accident investigation 3 Suicide 6 Could not b		M 1 Yes 2 No				- 10 - 10 - 10 - 10 - 10 - 10 - 10 - 10				
	or At offer of offer of offer of offer off	T I	4 ☐ Homicide determined	tory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	pital brail		298. Certifiler 150 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated										
	24 h Fun etely	Medical	29a. Certifler  (Check only one)										
	To the Hospital within 24 hours of the Euneral I completely filled		29b. Signature and title of coeffice 29c. License number 29d. Date signed (Month, Dgy, Year)										
	⊢ × ⊢ ŏ		1/1/1000 MD 142800 5/10/88										
	4		30. Name and address of person who completed causer of death (kern 23a) (Type, Print) / A										
	-/		314. S. UNION AND, MARK DE CARRE, Med 21.078 / 7. Blondo										
	Sta	te	31. Date filed (Month, Day, Year 199	25 Heavistan	Signature	1 1	20. 1	1	(	-	-	111	
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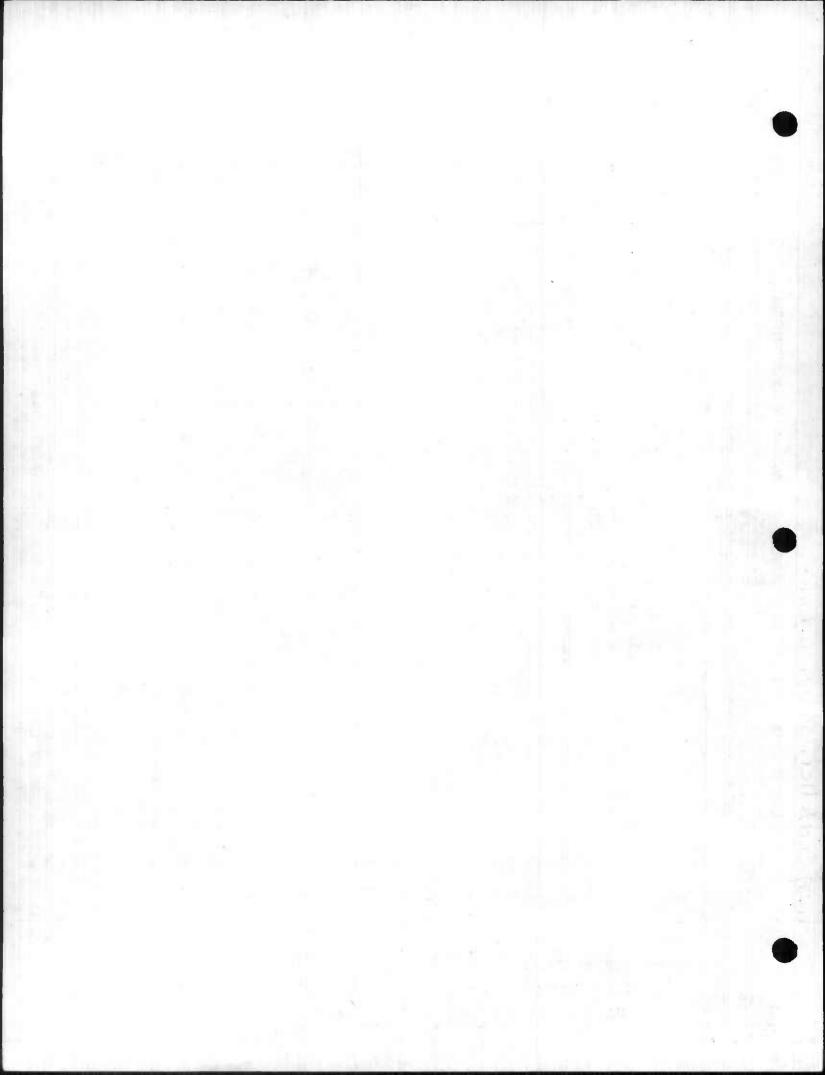
	Decedent's Neme (First, Middle, Last)	Certificate o		Reg. No.	3. Time of Death
nysician Medical	DONALD EUGENE	CARRUTH	Mon Ma y		Year 99 8:21pm
xaminer	4e Facility Neme (If not institution, give street end number)  Civista Medical Center		4b. City, Town, or Location of		of Deeth
neral ector	5. Sociel Security Number 6. Sex 10 M 2 F 7. Age (In )	yrs. lest birthday)   If Under 1 Yes  Yrs.   Months   Day		of Birth the pey, Year) 1913	rles  9. Birthplace (Stete or Forei Country) Alabama
ed est	Usual Residence of Decedent  10a. State 10b. County 10c.	. City, Town or Location			10d. Inside City Limit
notified at rector	Maryland Charles	Hughesville			1 □ Yes 2 🗘 N
2 2	10e. Street and Number 14375 Smallwood Drive	10f. Zip Code	20637	10g. Citizen of V	
by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in Armed Forcas?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	n U,S 13. Was Decedent of If Yes, specify Co	of Hispenic Origin? (Specify Yes uban, Mexican, Puerto Rican, e do <i>Specify:</i>	or No- tc.) 14. Race Bled Specify	e - American Indian, ck, White, etc. :: White
Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	16a. Decedent's Usuel Occ Give kind of work dor life. DO NOT use reti Superintend	ne during most of working ired)	Sand & Constru	
To Be	17. Father's Name (First, Middle, Last)  Edgar Carruth		18. Mother's Neme (First, )  Betty Pick		ne)
-	19a. Informant's Name/Relationship (Type, Print) Charles D Carruth		eet end Number or Rurel Route ), Bryantown, N		State, Zip Code)
	1 X Burial 2 Cramation 3 Removal from State	bb. Plece of Disposition (Neme of cemetery, cremetory or other potential orest Grove Cem	Date Date	20c. Location -	City or Town, State
#300 W	21, Signature of Europe Service Licenses  MARK G. BROHAWN MOOO	Neme and Add	etery Q5-18- dress of Fecility tt Funeral Hom ox 156, Waldor	e, Inc.	ata, Maryland
	23a. Part1. Enter the disease, or complications that caused the canock, or heart failure. List only one cause on each line.		tying, such as cardiec or respire	atory arrest,	Approximate Interval Between
an :ai er	Immediate Cause (Final disease or condition resulting in death) e.	2DIOVASCUL			Onset and Death  2 HR.
edicai Examiner	Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury	to (or as a consequence of):  NARY AR  to (or as a consequence of):	TERY DIS	SEASE	7 YR 9
ician/Me	d				
Phys	Pert II. Other significant conditions contributing to death but not PROSTATE CANCE		given in Pert I. 23I		ntribute to the cause of deat 3 Probably 4 Unknown
Completed by			246	a. Was an autopsy performed?	24b. Were autopsy findings aveilable prior to completion of cause of death?
Com				1 ☐ Yes 2 No	1 ☐ Yes 2 ☐ No
To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No  Hospitel: 1 ☐ Inpatient	all spin with a Minor C	26. Place of Death (Check		
tion: To	27. Menner of Deeth 1 Naturel 5 Pending 28e. Dete of Injury (Month, Dey Yea	28b. Time of Injury V	4 Li Nursing Home 5 L	scribe how injury occur	
Certification:	2 Sulpide 6 Could not be	At home, farm, street, fectory, offic	ce 26f. Loc	ation (Street and Numb or Town, Stete)	per or Rural Route Number,
Medical Certification	29a. Certifier (Check only one)  1 Cartifying Physician: To the best of my 2 Medical Examinar: On the basis of exam and manner stated.				
Σ	29b. Signature and title of cartifier		ense number	29d. Date signe	d (Month, Dey, Year)
	30. Name end address of person who completed cause of death	(Item 23a) (Type, Print)	29646		, 15, 99
	Joel Sewchand, MD 118 LaGrange	Avenue, P.O.Bo	ox 975. LaPlata	Maryland	20646



#### Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ucialan		Decedent's Nam	e (First, Middle, L	ast)						2. Date of De Month	Dav	Year	3. Time of De
iysician Medical		JAY		A		CLODF	ELTER			May 13	, 19	199	11:15
caminer	4a		Minotinstitution, g 1 Hospita		umber)				b. City, Town, or Bethesda			ty of Death	
		Social Security N	1	Sex	7. Age (In vis	s. last birthday)	If Under 1 Y		If Under 24 Hrs.	Dots -( Di	44.	gomer	~
neral ector	57	77-20-08	370	XXM 2□ F	73	Yrs.	Months D	ays	Hours Min.	July 24	, 1925	Nort	chece (State or F
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Funeral	11.	Marital Status		- Armed F		U,S. 13. V	Was Decedent 1 Yes, specify	of Hi Cuba	ispanic Origin? (S n, Mexican, Puer	pecify Yes or No o Rican, etc.)	)- 14. Ra	ace - Americ	
by Fi		1 Never Marri 3 Widowed	ied 2 Marned	1 Tes If Yes, G Yeer or I	2)(1) No live	1	I□Yes 2)	) No	Specify:		Spec	″γ: Whi	te
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	1		Co Clod		Wife				Road, Po				854
		. Method of Disg	position		20b.	Place of Dispo	sition (Name o	of r plac	9)	Dete	20c. Location	- City or To	own, State
		1 LABurial 31	☐Cremation #3 5 ☐ Other (\$pec	☐Removal from	State Ty				ardens t	5-17-19	99 Wal	dorf,	Maryla
	21.	Signature Fu	paral Service Lio	oneda	Ska	22	Name and A	ddres	Funeral	Home. I	nc		
ew		MARY	G. BRO	HAWN	M00053				56, Wale			2060	)4
	230	a. Part1. Enter the shock, or hea	he disease, or co rt failure. List onl	mplications that	caused the dea	ath. Do not ent	er the mode of	f dvin	n euch se cardia	or respiratory	rmet		Approximate
				y one cause on	each line.	-U. DO 1101 O11		· Oyan	g, such as cardian	or respiretory a	11034		Interval Between
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	disc	mediate Cause ( ease or conditio ulting in death)	(Final n			) PNE				; or respiretory a		1	Interval Between
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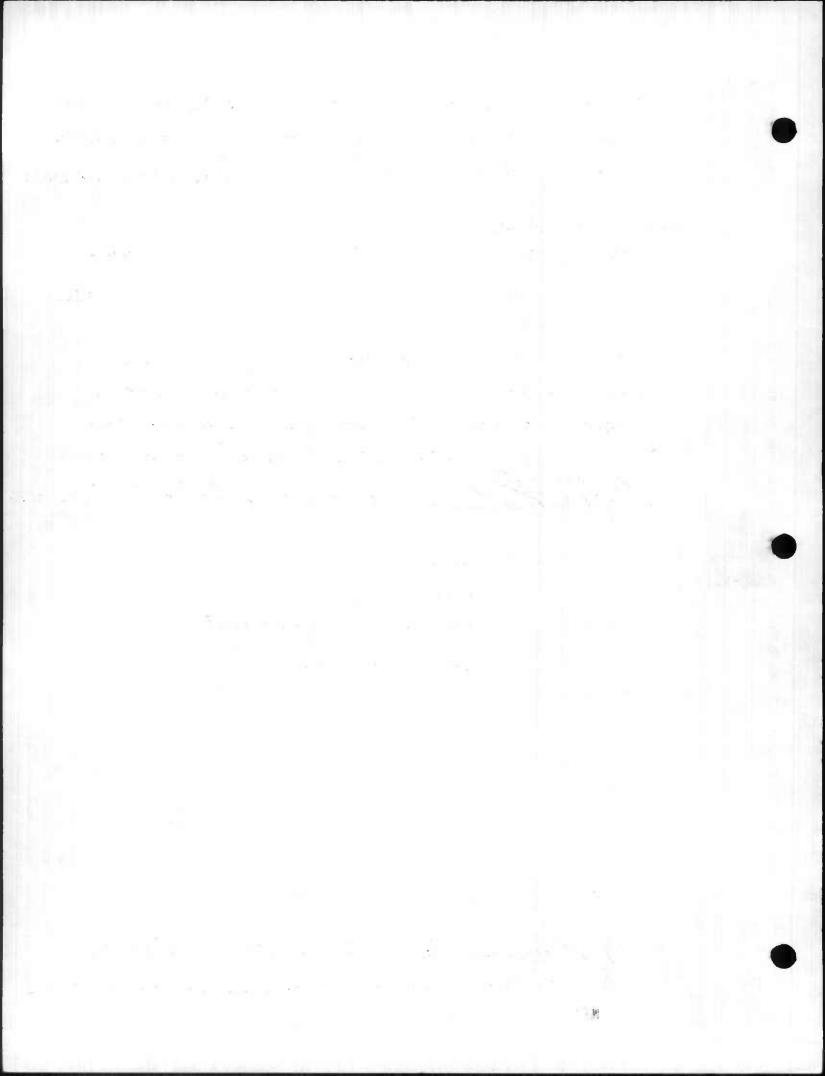
State of Maryland / Department of Health and Mental Hygiene

						Certifica	ate of	Death	R	eg. No.	1	1201	
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J	/Medi		RENA	ELEA	NOR		CC	OHEN		7 19	99	22:24	
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	pu ≱		Usuei Residence of Decedent  10a. Stete 10b. County	100	City. Town	or Location					10	0d. inside City Limits	
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020	d within 72 hours after death with the Maryland liene. Then "natural", or flems 23a or 28a-f show the Medical Examinet must be notified at	by Funeral	11. Meritel Stetus  1 Never Merried 2 Merried  3 Widowed 4 Divorced	12. Wes Decedent Ever Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes:	n U,S.			dispanic Origin? (Spen, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		ce - America ck, White, e	etc.	
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Baltimore,	permit. Pages 1 and 2 Department of Health a Important: if Item 27 it any Injury or other tra once.		20e. Method of Disposition  1 ☒ Buriei 2 ☐ Cremetion 3 ☐  4 ☐ Donetion 5 ☐ Other (Specify	Removei from State	cemetery	Disposition (A r, cremetory o erans	other ple		Dete :	20c. Location Chelter			
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Вох	death co	lan	_	d							i		
o.	the a	/sic	Pert II. Other significant conditions co	ontributing to death but not	resulting in	the underlying	cause giv	ven in Part i.	23b. Dld to	bacco use co	ntribute to	the cause of death?	
s, P.O.	ules that the death cer signed by the attendir id be detached for use	by Phy	diabetes			_			1⊠ Ye	e 2□No	3 Prob	ebly 4 Unknown	
Records,	been shoul	Completed							24a. Wes a perform		con	ore autopsy findings ollabie prior to npietion of cause death?	
	The ate h	5							1 □ Y€	s 2 No	1 🗆	Yes 2□ No	
/ita	cian: artific actor,	Be	25. Wes case referred to medical axaminer?						th (Check only on	θ)			
Division of Vital	Attending Physician: The lavar death. ector: After this certificate has by the funaral director, page 2	on: To	1 ☐ Yea 2 ☐ No	Hospitel: 1 Inpatient  28a. Dete of Injury (Month, Day Yea		lury	28c. Injur Wor	y et rk?	ome 5 Reaide 28d. Describe ho			)	
S	Attending ir death. ector: After by the funa	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Piece of injury - /		M		Yes 2□No	not Leasting (Ct	aning an of Africa	0	1 Sauta Atumb -	
<u>N</u>	2 2 2 2	Certification:	4 Homicide determined		28f. Location (St. City or Town		oer or mura	rioute Number,					
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in	edical	29e. Certifier 1X Certifying Phy (Check only one) 2 Medical Exam	vaicien: To the best of my iner: On the bests of exame end menner steted.	knowledge, ninetion and	deeth occurre for investigetion	d et the tir on, in my o	ne, dete and piece, pinion, death occur	and due to the ce red et the time, de	ouse(s) and ma ete end piece,	annar as sta and due to	ated. the cause(s)	
	To the	Σ	29b. Signeture and title of certifier			2	9c. Licens	e number	25	d. Dete signe	d (Month, L	Dey, Year)	
			1 folia o	uu			D 40	370		5/18/9	99		
	0		30. Name and address of person who o		item 23a) (1	ype, Print)							
			Peter Wisniewski 31. Dete filed (Month, Dey, Year)		on at		Pri	nce Frede	erick, M	20678			
	Sta Registr		MAY 1 Q	32. Registrar's S	gneture	4	1	no Val					

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State of Maryland / Department of Health and Mental Hygiene

					Certifica	ate of	Death		Reg. No.	117202
Physician		Decedent's Name (First, Middle, La: Johanna	st) Mart	ha		Carı	cick	2. Date of De Month May 1		3. Time of Dec
/Medical Examiner	40	Facility Name (If not institution, give Southern Maryla		al			4b. City, Town, or Clinton	Location of Deat	h 4c. County of	Death George's
Funeral Director		Social Security Number 6. S	-	e (In yrs. las	t birthday) If Und Month	ler 1 Year s Days	If Under 24 Hrs	8. Date of Bii (Month, Di	th ay, Year)	Birthplace (State or Fo Country) Zechoslovak
100		sual Residence of Decedent la. State 10b. County		10c City 1	Town or Location	1		sept.	0,130302	10d. Inside City L
red at		200	annala.		Clinton					1 □ Yes 2(
23a or 28a all be not al Olrec	10	Jaryland Prince G e. Street and Number 9106 Pineview L			10f. 2	Zip Code 735			10g. Citizen of Wha	st Country?
in recent by types.  marked other than 'naturel', or items 23a or 28a-f show imstic event, the Medical Examiner result be notified at To Be Completed by Funeral Director	11.	. Marital Status  1 Never Married 2 Married  3 V Widowed 4 Divorced	12. Was Decedent Armed Forces? 1  Yes 2 1 It Yes, Giva Year or Dates:				Hispanic Origin? (Span, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. White
Department of regard are continued or in page as important; if item 27 is marked other than "nature any injury or other traumatic event, the Medical once.  To Be Completed		15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 12+h	ducation ide completed) College (1-4or 5	5+)	16a. Decedent's Us (Give kind of v life. DO NOT		ipation a during most of wo ed)	orking	16b. Kind of Busin	
event, Be C		. Father's Nama (First, Middle, Last)			nonenax	5±	18. Mother's Na	me (First, Middle	, Maiden Sumame)	3
is marked other than raumatic event, the I	2	Martin Le	SZNET Type, Print)		19b. Mailing Addre	ss (Stree		lippine	Schuk per, City or Town, Str	
em 27 is		Christopher Car	rick (Son)					oodland	Park CO 8	30863
Important: If item 27 is any injury or other trau	20	a. Method of Disposition  ***Burial 2   Cremation 3   4   Donation 5   Othar (Specification of the control of t			e ot Disposition (A befery, crematory o ington Na		nal Cem.	y <b>P9</b> , 1999	20c. Location - Cit Arlingtor	n Virginia
important: it any injury o	21	1. Signature of Puneral Seg/ColSicen							ral Home, Road Cli	Inc. inton, MD 2
physicien and street transit street buriel-transit street buriel-t	23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each lina.  Immediata Causa (Final disease or condition resulting in death)  a. Sepsis  Due to (or as a consequence ot):  Sequentially list conditions,  Due to (or as a consequence ot):									
		equentially list conditions, any, leading to immadiata suse. Enter Underlying ause (Disease or Injury at initiated events sulting in death) Last		Due to (or e	ub tu	f):	lurs.	dout		
d by the attending deteched for use Physician/M	Pa	nt II. Other significant conditions o	ontributing to death b	ut not resulti	ng in the underlying	cause g	iven In Part I.		tobacco use contri	Drobably 4 Un
2 should be pleted by								24a. Wa	s an autopsy ormed?	24b. Were autopsy tind available prior to completion of caus of death?
is certificete has be director, page 2 s	L							10	Yes 2 No	1□Yas 2□No
rector rector	25	5. Was case raterred to medical examiner?  1 Yes 2 No	Hospital:		NO tradical 20	000	thor	eath (Check only		(Cassibil)
		27. Mannef of Death  1 Natural 5 Panding 2 Accident Investigation  28a. Data of Injury (Month, Day Year)  28b. Time of Injury 28b. Injury at Work? 1 Yas 2 No					how injury occurred			
重量		E T Veridalis		ury - At hom	a, tarm, street, fact			28f. Location City or To	(Street and Number own, State)	or Rural Routa Number
重量		3 Suicide 6 Could not be datermined		o. (opecity)						
重量	29	3 Suicide 6 Could not be datermined	28a. Place of Inj	of my knowle						
# -	29	3 Suicide 4 Homicida  6 Could not be datermined	building, at	of my knowle	n and/or investigati	on, In my				d dua to the causa(s)
重量	29	3 Suicide 4 Homicida  6 Could not be datermined  7 Cartifying Ph. (Check only one)  7 Medical Examples	system: To the best of manner standard manner	of my knowle t axamination atad.	and/or investigati	on, In my 29c. Licer	opinion, death occ	curred at the time	, data and place, and	d dua to the causa(s)



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month 6:45 PM GRACE DOUGLAS MAS /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** DOCTORS HOSPITAL PRINCE GEORGES LANHAM 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dey, Year) Birthplace (Stete or Foreign Country) **Funeral** 1 M 2 XF Deys Yrs. Director 577-60-0211 83 May 31,1915 Washington, D.C. Usual Residence of Decedent Maryland 21215-0020
Of should be filed within 72 hours effer death with the Maryland of 71 la marked other than "neturel", or items 23a or 28a-4 show traumatic event, the Madical Exp. Internation and items 23a or 28a-4 show traumatic event, the Madical Exp. International and items 23a. 10a State 10b. County 10c. City, Town or Locetion 10d. Inside City Limits Yes 2 No Directo Maryland Prince Georges Capitol Heights 10e. Street and Number 10g. Citizen of What Country? 714 Iona Terrace 20743 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2\( \) No If Yes, Give Yeer or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, spacify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American indien, Bleck, White, etc. 11. Meritel Status permit. Pages 1 end 2 should be filed within 72 hours effer to Depertment of Health end Mental Hygiene. Important: if Item 27 Is marked other than "naturel", or ite any injury or other traumatic event, the Medical Examina 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Specify: Black þ 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) G.A.O. Government 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Meiden Surneme) Frank Parker Mary Hughes 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Richard H. Douglas / Son 606 Sisalbed Court, Capitol Heights, Md. 20743 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 ABurial 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Harmony Memorial Park 5/10/99 Landover, Maryland 22. Neme end Address of Fecility ALEXANDER S. POPE FUNERAL HOMES 23e. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one ceuse on each line. 20747 Approximete Intervel Between Onset end Deeth **Physician** Intestinal Obstanction /Medical Immediate Ceuse (Final Few days diseese or condition resulting in deeth) Examiner Examiner Possible Gastropareous weeks/months Adhesions + physicien end the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): Dindelie Years Uncontrolled Physician/Medicai Due to (or es a consequence of) Pert II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detec 1 Yes 2 No 3 Probably 4 Unknown ò 24b. Were autopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? pege 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Eveneral Director: After this certificately filled in by the funeral director; Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 1 Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in Certifying Phyelcian: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end menner steted. 29e. Certifier Medical 29b. Signeture end title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year) 53411 SH Jahran. 1999 MD 30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) JC Shesodn, 3060 Mitchellville Rd. # 103, Bonie, 20716 M.D

**DHMH 16 Rev 6/95** 

Registrar

31. Date filed (Month, Dey, Year)

MAY 1 1 1999

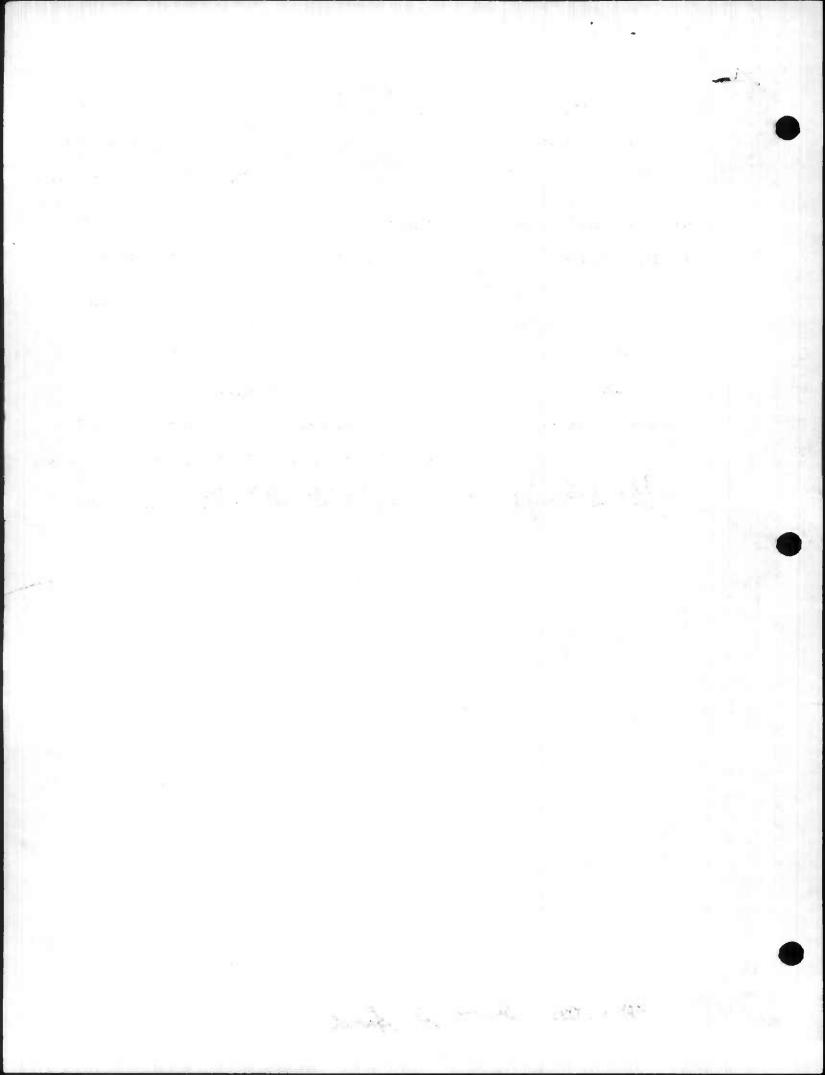
32 Registrer's Signature

P.O. Box 68760,

Records.

Division of Vital

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	and	-	Usuel Residence of Decedent  10a. Stete 10b. County	10c. C	ity, Town o	or Location						10	d. Insida City Limi	Its
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	n 72 hours after deeth w *natural*, or items 23a edical Examiner munit	Funeral	11. Maritel Status	12. Was Decedant Ever in U Armed Forces?	J,S.	13. Was Deced	ent of F	lispanic Ong an, Mexican	in? (Spe	ecify Yas or No- Rican, etc.)		- Amaric k, White,		
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and	e filed al Hygie other vent, b	Bec	17. Father's Neme (First, Middle, Last)					18. Mothe	r's Neme	(First, Middle, N	Maiden Sumam	Θ)		
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			30. Neme end eddress of person who co	HURST MO	73	205 13	BAL	T. AV	E.	COLLE	GE PI	RICA	10 2074	-0

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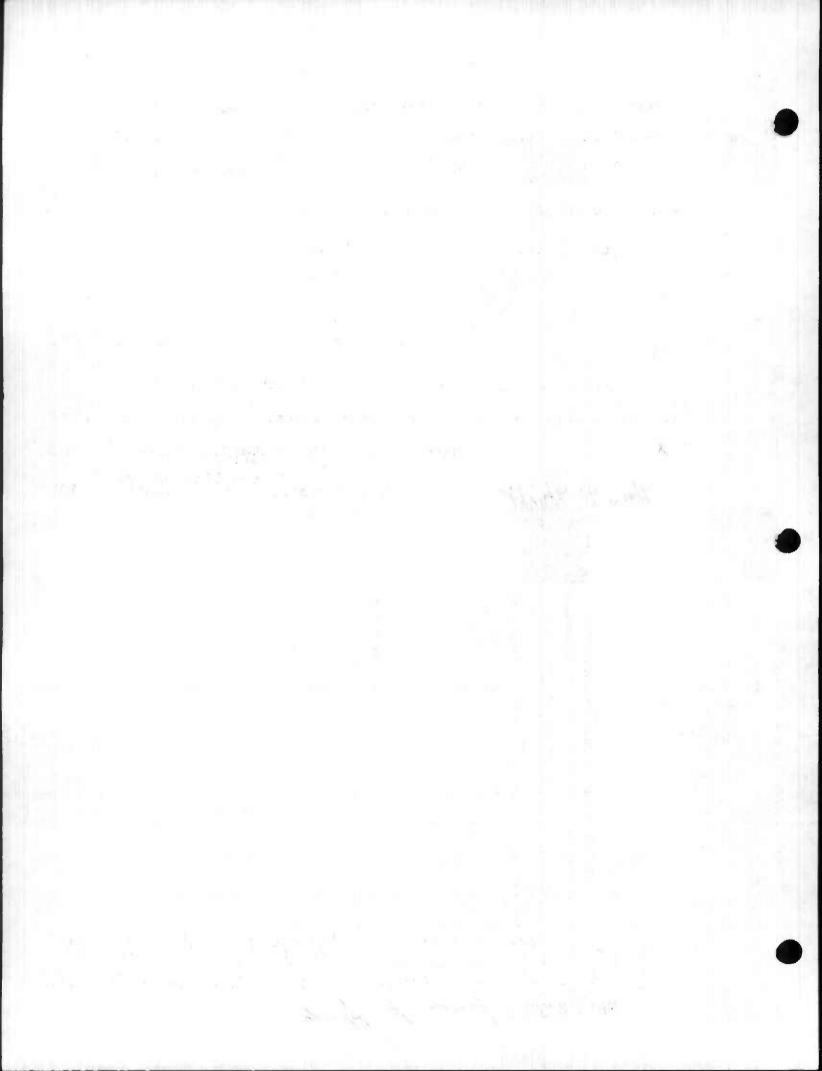
State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene

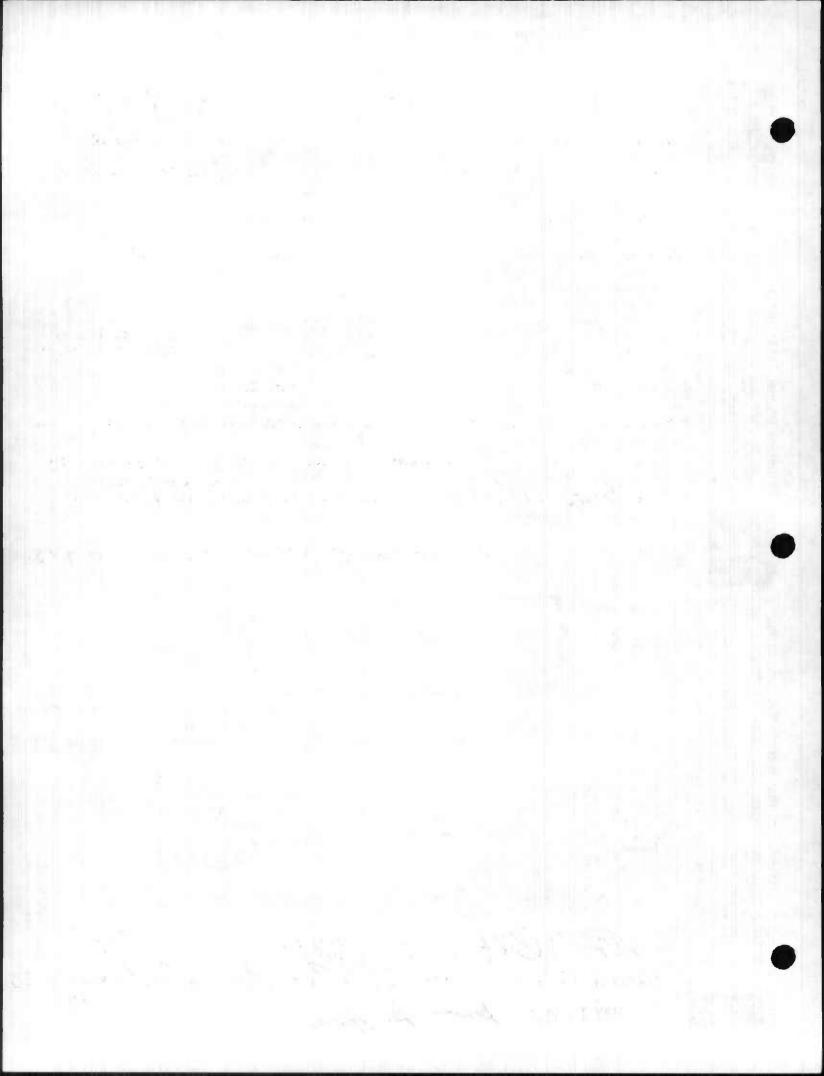
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month 11, 1999 Josephine DiBlasi May 10;40 am Rose /Medical 4e. Fecility Name (If not institution, give streat end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Westminster Nursing Home Westminster Carroll If Undar 1 Yaar If Undar 24 Hrs. 7. Age (In yrs. lest birthday) **Funeral**  Birthpleca (Steta or Foreign Country) Deys 1□ M 2 F Months Hours 216 01 7359 83 Yrs Director 1916 Usual Residence of Dacedent permit. Peges 1 and 2 should be filled within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or no once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Carroll Sykesville Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 6201 Cutsail Ave. 21784 U.S.A. Completed by Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yaar or Datas: Was Dacedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 14. Raca - Americen Indien, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondery (0-12) Homemaker College (1-4or 5+) Domestic 11 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumama) Be Girlando Sarah (Unknown) Salvadore 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Francis P. Larabee (Son) 6201 Cutsail Ave. Sykesville, Md. 21 784 20e. Method of Disposition 20b. Piece of Disposition (Neme of cemetery, cremetory or other p 20c. Location - City or Town, Stata Gardens of Faith Cemetery 5/14/99 Burial 2 Cremetion 3 Removel from Stete
4 Donation 5 Other (Specify) Baltimore, Md. 21. Signature of Funerel Service Licensea 22. Name end Address of Facility ykesville, Md. 21784
Haight Funeral Home & Chapel Box 195 thet caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, a on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Fine) diseasa or condition rasulting in deeth) en years Examiner Due to (or as e consequence of) Examiner Hospital or Attending Physician: The lew requires thet the death certificate be executed ettending physician and for use es the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In deeth) Lest Due to (or es a consequance of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? ate hes been signed by pege 2 should be detec 1 Yee 2 No 3 Probably 4 Unknown þ Completed 24b. Were eutopsy findings aveileble prior to completion of cause of daeth? 24e. Wes en eutopsy performed? certificate 1 Yes 2 No 1 Tyes 2 No 25. Was cese refarred to medicel examiner? Be 26. Piece of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Manner of Deeth 28e. Date of Injury (Month, Dey Yaer) 28c. Injury at Work? 28d. Dascribe how Injury occurred 1 Netural 5 Pending investigation efter deeth. 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Sulcide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as steted.
2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner stated. 29a. Certifier Medical (Check only one) 29b. Signeture end title of certifier 29d. Dete signed (Month, Day, Year) 30. Name and address of person who completed cause of death (item 23e) (Type, Print) 114 Business Jun 31. Dete filed (Month, Day, Year) MAY 1 2 1999 32. Registrar's Signeture State Registrar



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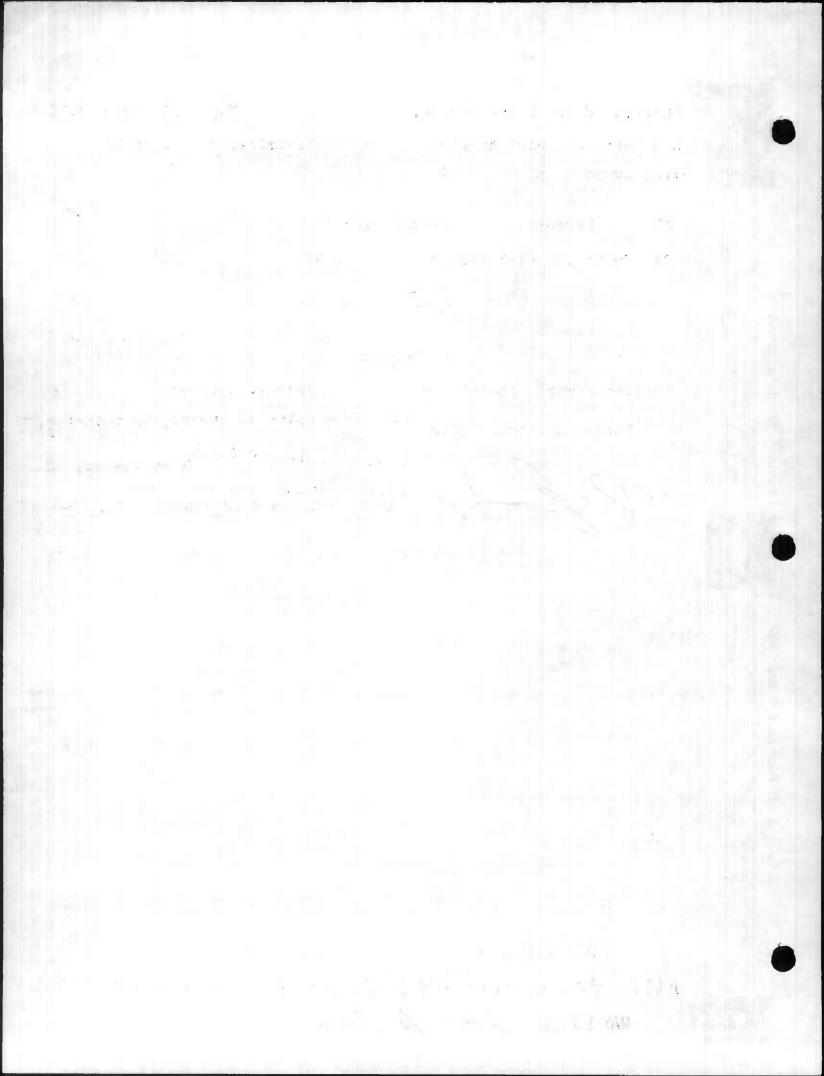
State of Maryland / Department of Health and Mental Hygiene

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To	-	a. Informant's Name/Relationship (7)	me Print)	10h Mailir	na Address /St	reet and Number or F	Culver	City or Town St	ate Zin (	Code)
		Robert Dodson, Jr				Fowler Rd,				
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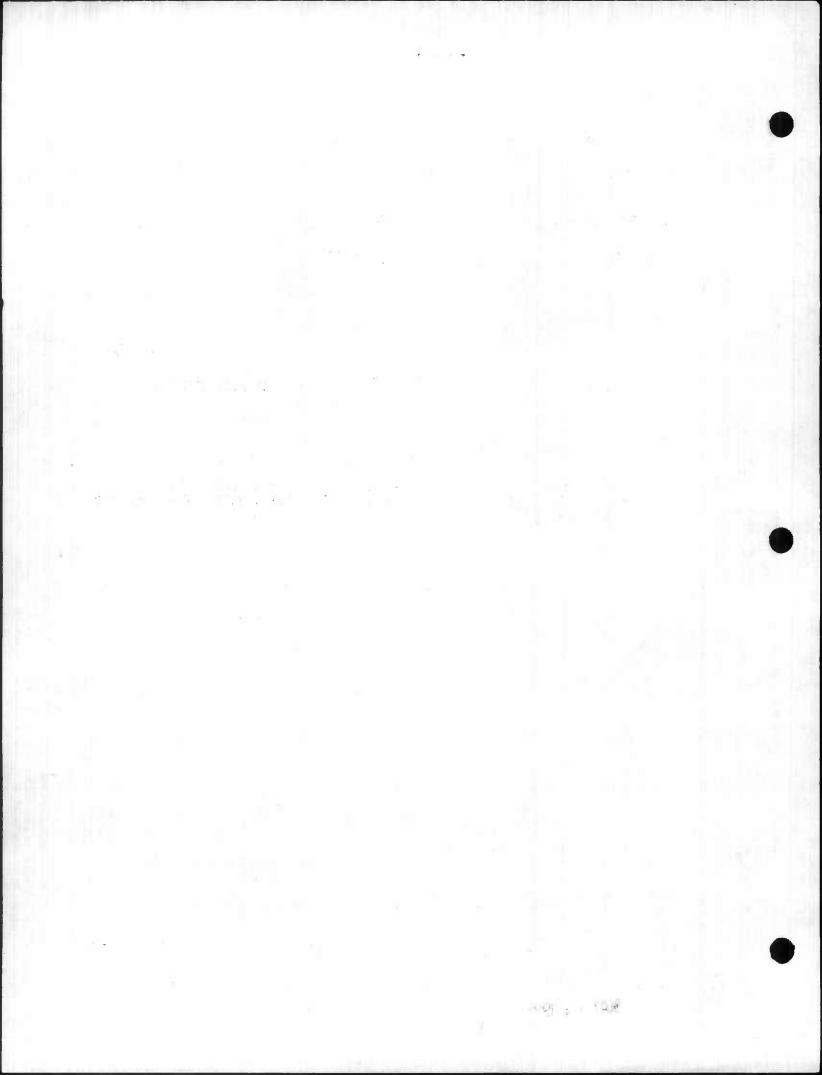
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Tima of Death Пау Month Physician John Daly May 11, 1999 3:15 AM /Medical 4a Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury Center: Genesis ElderCare Salisbury, MD Wicomico If Under 1 Year If Under 24 Hrs. 8. Data of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 1 M 2 □ F 80 Yrs. 02-07-1919 Director 579-05-3267 WASHINGTON, D.C Usual Rasidanca of Decedant 10a Stata 10c. City, Town or Location 10b. County 10d. Inside City Limits show the Maryta 1 Yas 2 No Director 28a-f DELAWARE SUSSEX OCEAN VIEW 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code Berns 23a or must be 35 OSPREY LANE 19970 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Raca - Amarican Indian, 11. Meritel Stetus Black, Whita, atc. Pages 1 and 2 should be liked within 72 hours after mort of health and Medical Hygiene.

with if Bern 27 is mericad other than "natural", or its usy or other traumets event, the Medical Examines usy or other traumets event, the Medical Examines. 1 Yas 2 No If Yes, Giva 1 Nevar Married 2 Merried Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: à WHITE 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) College (1-4or 5+) MAILER NEWSPAPER 17. Father's Nama (First, Middla, Last) 18. Mother's Nema (First, Middle, Maiden Sumema) Be JOHN DILLON DALY THERESA M.N. UNKNOWN 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) JEANNETTE D. DALY/WIFE 35 OSPREY LANE, OCEAN VIEW, DELAWARE. 19970 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Seurial 2 Cremation 3 Removal from Stata 4 Donation 5 Dothar (Specify) Department of Important: If any injury or GEORGE'S CEMETERY 05-14-99 CLARKSVILLE, DELAWARE 21. Signature of Puneral Service Licensee 22. Nama and Addrass of Facility
MELSON FUNERAL SERVICES, LTD. alse WEST AVENUE, OCEAN VIEW, DELAWARE. or complications that ceused the death. Do not enter tha mode of dying, such as cardiac or respiratory errest, st only one ceuse on each line. Approximata Interval Batween Onset and Death Physician /Medical Immediata Causa (Final Neumonra diseesa or condition rasulting in deeth) Examiner PARKINSON'S Examiner morred or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immediata causa. Entar Undarlying Ceusa (Diseesa or Injury that initiated avants rasulting in death) Last burial-tran pue Dua to (or as a consequence of) P.O. Box 68760. Physician/Medical the Dua to (or as a consequance of) 8.8 Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 3 Probably 4 → Onknown 1 Yee 2 No Division of Vital Records. should be d þ Completed 24b. Wara autopsy findings available prior to 24a. Was an eutopsy performed? complation of cause of death? page 2 2 DNO certificate 1 Yas 1 Yes 2 No funeral director. 25. Was case rafarred to medical axaminar? Be 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidanca 8 Othar (Specify) 1 Yas 2 No edical Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28b. Time of 28a. Deta of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Netural 5 Panding invastigation 1 ☐ Yas 2 ☐ No death. 2 Accidant 24 hours after deat Funeral Director: 6 Could not be datamined 3 Suicide 28f. Location (Straet end Number or Pural Routa Number, City or Town, Stete) 28e. Plece of Injury - At homa, farm, street, factory, offica building, etc. (Specify) filled in by 4 Homicide Hospital Certifying Physician: To tha best of my knowledge, deeth occurred at tha tima, data and plece, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plece, and due to the ceuse(s) end manner stated. 29a. Certifier completely f (Check only one) within 2 To the To the 29b. Signatura and titla of certifier 29c. Licansa number 29d. Date signed (Month, Day, Year) Ulo D 39813 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) Michael R. Atkins, M.D. 1104 Healthway Dr., Salisbury, MD 21804 MAY Year) 32. Registrar's Signatura State Registrar



### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death Menth **Physician** 12 WALTER LEE DENNIS 99 12:05 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7431 Libertytown RD Berlin Worcester 8. Data of Birth (Month, Day, Year) 5. Sociel Security Number Birthplaca (Stata or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** XXXM 2□ F Months Days Hours Min 217-36-1783 78 Yrs. MD Director Usual Rasidance of Decedant the Marylend 10e Stete 10h County 10c. City. Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or hama 23a or 28a-f show trsumatic event, the Madical Examiner must be notified at Worcester MD Berlin 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? with 7431 Libertytown RD 21811 USA permit. Peges 1 end 2 should be filed within 72 hours effer deeth to Department of Health end Mental Hygiene. I'mportant: If flem 27 is marked other than "natural", or itemm 23s any Injury or other traumetic event, the Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 14. Race - American Indien, Black, Whita, atc. Wes Decedent of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 11. Maritel Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: white p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) Eiamantary/Secondary (0-12) Collega (1-4or 5+) Owner/ Operator Saw Mill 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Meidan Surnema) Rilley P. Dennis Dora Smack 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) 7431 Libertytown RD Berlin, MD Ina Dennis/ Wife 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Ramovel from State 5/14/99 Libertytown, MD Riverside Cemetery 4 Donetion 5 Other (Specify) 22. Nama and Address of Facility ervice License Burbage Funeral Home 108 William St. Berlin, MD

108 William St. Berlin, MD

109 William St. Berlin, MD

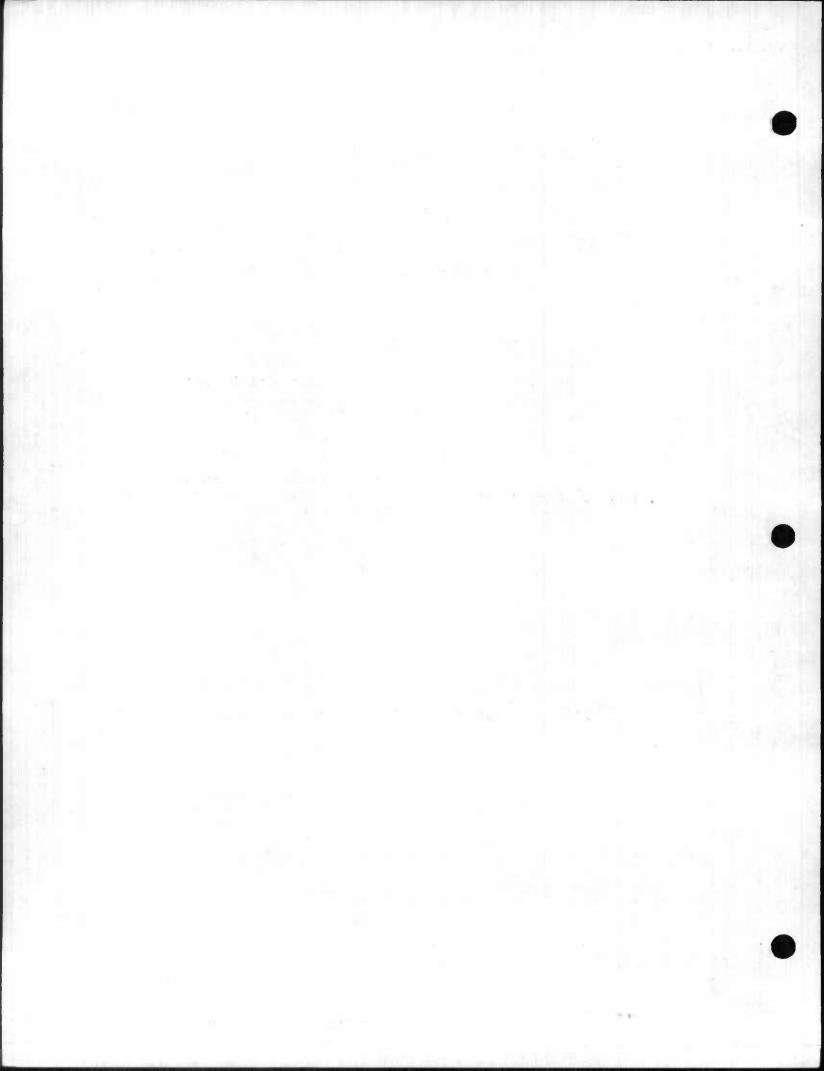
109 William St. Berlin, MD

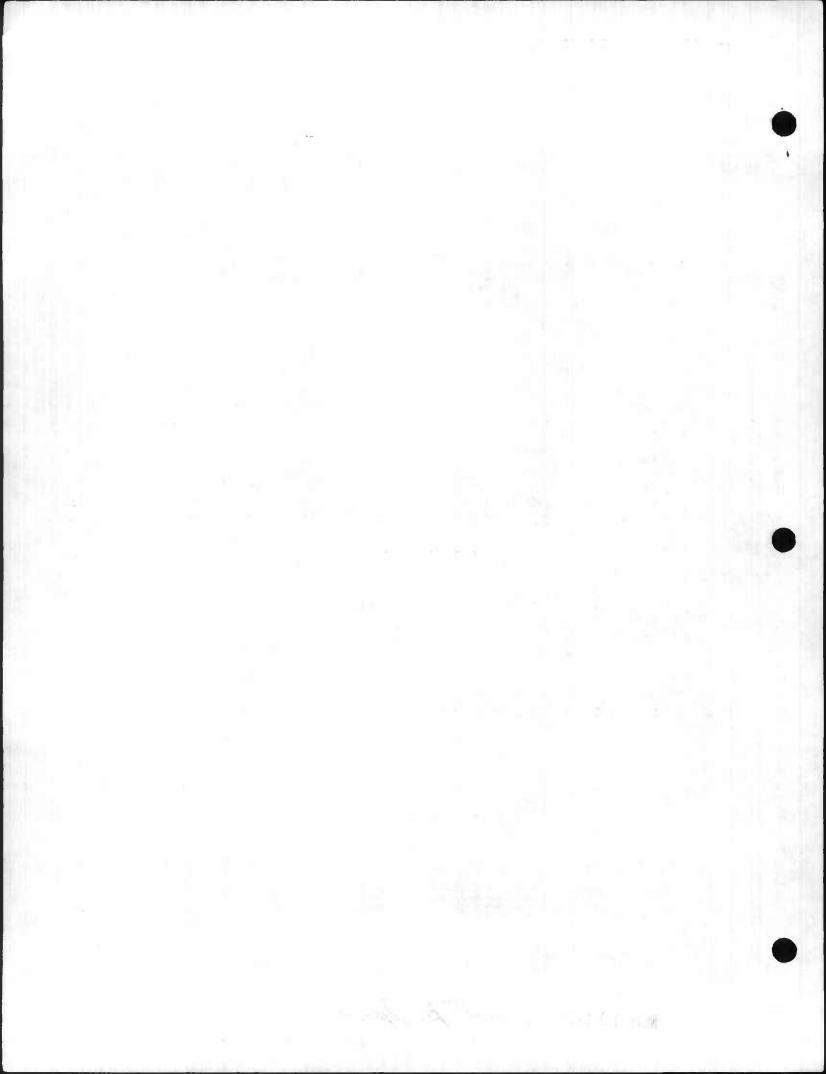
109 William St. Berlin, MD Berlin, MD Approximate Interval Between Onsat and Death **Physician** /Medical Immediata Causa (Final Tancreatic disaasa or condition rasulting in daath) Examiner Dua to (or as a consequance of): Examiner 9 0 physician end the burial-transit Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disaasa or injury that Initiated events resulting in death) Last Dua to (or as a consequence of): certificate be exec Magi Division of Vital Records, P.O. Box 68760, Physician/Medicai Dua to (or as a consequence of): 98 980 for 23b. Did tobecco use contribute to the cause of death? deteched i Pert II. Other significant conditions contributing to death but not resulting in the undarlying ceusa given in Part I. signed by t 1 Yes 20 No 3 Probably 4 Unknown 2 24b. Wara autopsy findings evailable prior to Completed 24a. Was an autopsy performed? peed complation of causa of death? The law page 2 hes 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificate or Attending Physician: funeral director, 25. Was case rafarrad to medical axaminar? Be 26. Pleca of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 10 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Data of Injury (Month, Day Year) 27. Manner of Deeth 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 28b. Tima of Natural 5 Panding 1 Yas 2 No 24 hours after death. Invastigation 2 ☐ Accidant 6 Could not be datamined Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) filled in by 4 ☐ Homicida Hospital 29a. Cartifia 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and due to tha ceuse(s) and menner as stated. Medicai 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the ceusa(s) end menner stated. (Check only one) within 2 the 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signature and title of og 0 99 on who completed caus 23a) (Type, Print), of per Kace back 31. Date filad (Month, Dey, Year) 32. Registrar's Signatura State MAY 1 4 1999 Registrar

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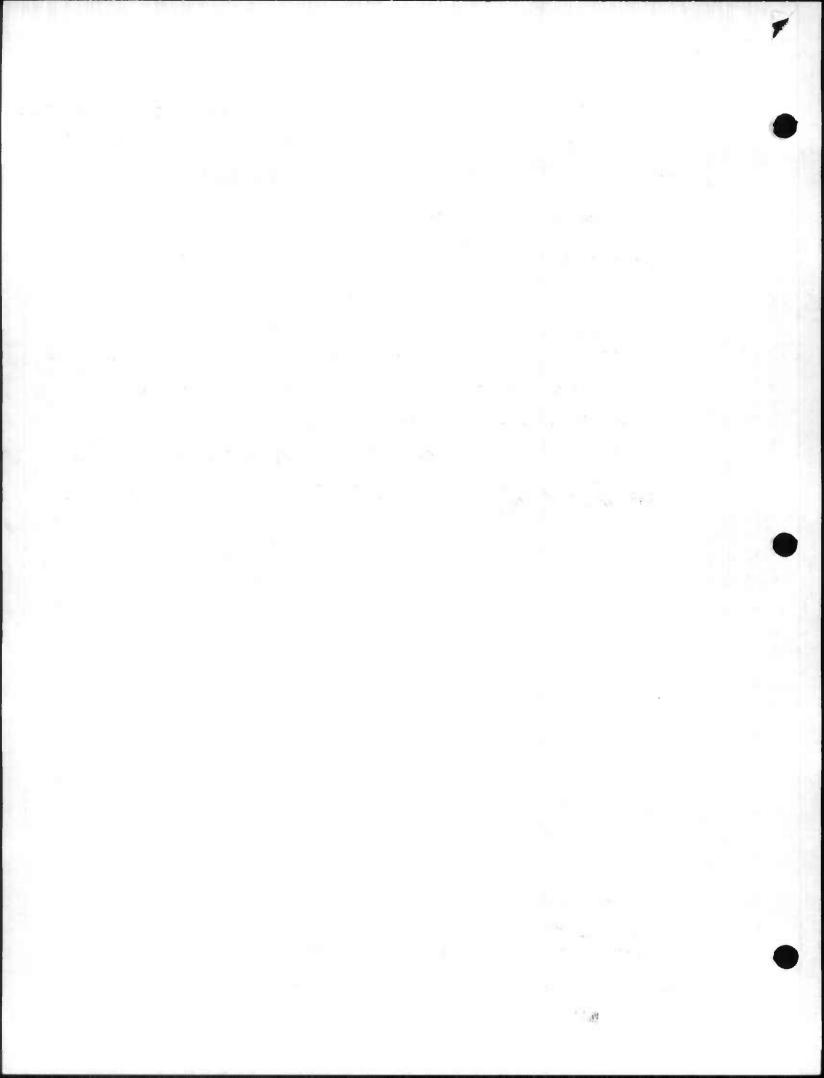
	1 Decederate Name /First Middle Le		Ce	rtificate of	Death		Reg. No.	11211
Physician	Decedent's Neme (First, Middle, La					2. Date of De Month	etn Dey Yea	3. Time of Death
/Medical	Mariana Kooser					MAY	17 1999	
Examiner	4a Facility Name (If not institution, giv				4b. City, Town, or		10.000.00	
	Sacred Heart H				Cumber1		Allega	ny
Funeral Director	5. Sociel Security Number 6. S 200-28-7799	Sex 7. Age (h	6 Yrs.	If Under 1 Year   Months   Days	Hours Min.		9. 8 9. Year) 9. 8 2, 1922P	irthplace (State or Foreign Country) ennsylvani
how how	10a. State 10b. County		Oc. City, Town or L					10d. Inside City Limits
the Ma	ennsylvania Be	dford	Hyndman	10f. Zip Code			10g. Citizen of What (	1 □ Yes 2 No
th with	PO Box 218			1554	5		United S	
within 72 hours after death with the Maryland ene. "satural", or items 23e or 28e-f show to Medical Examinar man be notified at empleted by Funeral Directog	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No if Yes, Give Year or Detes:	r in U,S. 13.	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🗖 No		Specify Yes or No to Rican, etc.)	14. Race - An Black, Wi Specify: Wh	
led within 72 ho bygiene. The then "neturn it, the Medical I	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	dent's Usual Occu e kind of work done DO NOT use retire	pation during most of wo d),	rking	16b. Kind of Busines	
285 0	17. Father's Name (First, Middle, Last,	4	Pna	rmacist	40 Mathada Na	ma (Cinnt Adidalla	Pharmace Maiden Sumame)	utical
Se Se	William J. Koos				Mary Et			
	19a. Intormant's Name/Reletionship (					ural Route Numb	er, City or Town, State	, Zip Code)
	Freeman P. Deis			Box 218		an, PA	15545	
ages ent of rt: If It	20a. Method of Disposition  XXBurial 2 Cremation 3 C 4 Donation 5 Other (Specification)			osition (Name of emetory or other ple Cemeter		Date , 1999	Hyndman,	
permit. Pa Department Important: any injury phos.	21. Signeture of Funeral Service Licar		2		ess of Facility H. Zeig	ler Fur	neral Hom	ylvania e
Physician	23a. Part1. Enter the disease, or com shock, or heart feilure. List only	plications that caused the one cause on each line.						Approximate Interval Between Onset and Death
/Medical Examiner	Immediate Cause (Finei disease or condition resulting in death)	aC	DNGOJ	アレゼ	HART	FAIL	rō	1 WEEK
ě		Due	e to (or as a conse	quence of):				
icate be executed physician and s the burial-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	e to (or as a conse	quence of):				
5 0 0	that initiated events resulting in death) Last	Due	to (or as a conse	quence of):				
death cer e attendir od for use								1
at the death cert d by the attendin eteched for use Physiclan/M	Pert II. Other significant conditions of	ontributing to death but notice of the second of the secon	1	underlying cause gi	ven in Pert I.	23b. Did	/	re to the cause of death?  Probably 4 Unknown
es the igner in the period in	HIPCHE	TIDICIOCI	1000					
The law requires that the death certains has been signed by the attendin page 2 should be detached for use Completed by Physician/N							en autopsy 24t emed?	Were sutopsy tindings available prior to completion of cause of death?
certificate has riector, page 2						10	Yes 2 DN6	1 Yes 2 No
ertific sctor. Be	25. Was casa referred to medical axaminer?				28. Place of De	eth (Check only o	one)	
ng Physic frer this ce uneral dire on: To	1 Yes 2 No  27. Menner of Death 1 Netural 5 Pending	Hospitel: 1 Ampatient  28a. Dete of Injury (Month, Dey Ye	her: 4 □ Nursing b ry at rk?		denca 8 Other (S)	pecify)		
To the Hospital or Attending Physician: The is within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page Medical Certification: To Be Com	2 Accident investigation 3 Suicide 6 Could not be determined		]Yes 2□No	28f. Location ( City or To	Street and Number or vn, State)	Rural Route Number,		
To the Hospital within 24 hours a To the Funeral I completely filled Medical Ce	29s. Certifier (Check only one) 1 Certifying Ph	ysician: To the best of m hiner: On the basis of exa and manner stated	amination and/or in	h occurred at the ti evestigetion, in my	me, date end place opinion, death occi	s, and due to the urred et the time,	cause(s) and manner date end piece, and d	es stated ue to the cause(s)
outhin comple	29b. Signature and title of certifier			29c. Licen	se number ,		29d. Date signed (Mo	nth, Day, Year)
E3E8	· Soul	- PHYSIC		P	50844		10	999
0	30. Name and address of person who	completed cause of death	(Item 23a) (Type,	2 Strow	DRIVE	ourses	CLAND, ME	21502
State Registrar	31. Date tiled (Month, Dey, Year)	32. Registrar's	-	,				



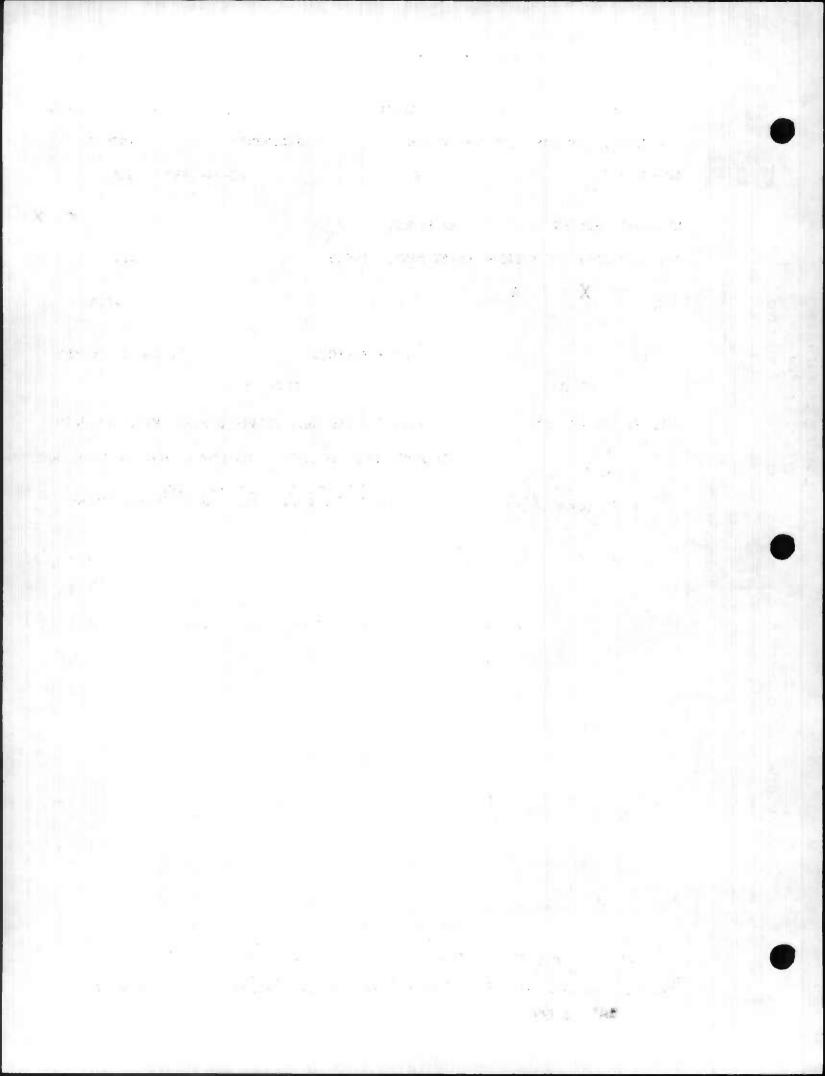


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			State of F		Certificate	of Death		Reg. No.	9 1	7210
П	Physici	ian	Decedent's Neme (First, Middle, Last)				2. Date of Dea Month	ath Day	Yeer	3. Time of Death
·	/Medi		Eugene Calvin DODSO				May 1	4, 199		2:30 pm
A	Examir	ner	4e. Fecility Neme (If not institution, give street and number 987 Ed Joy Road	7)			Location of Deeth			
	Funeral Director	ľ		Age (In yrs. last birt	thday) If Under 1 Yrs. Months D	Lusby  Year If Under 24 Hr ays Hours Mir		Calv V, Year) B, 1911		ce (State or Foreign
	P		Usual Residence of Decedent				3			
	a-f show	ctor	MD 10b. County Calvert	10c. City, Towr Lusby					10d	inside City Limifs  1 ☐ Yes 2 No
	h with the	al Director	10e. Street and Number 987 Ed Joy Road		10f. Zip Co			10g. Citizen of V USA	Vhet Country	7
020	72 hours efter deeth with the Meryland "naturel", or items 23s or 28s-f show idical Examiner must be notified at	by Funeral	11. Meritel Stetus  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Deceder Armed Force 1 Yes 2 Very Yes, Give Yes or Dates	s? INo	13. Was Deceden If Yes, specify 1 Yes 202	of Hispanic Origin? ( Cuben, Mexican, Pue No Specify:	Specify Yes or No- rto Ricen, etc.)	14. Race Blace Specify	e - American ck, White, etc : Whj	
altimore, Maryland 21215-0020	30	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-40	( 5+)	Decedent's Usuel C (Give kind of work of life. DO NOT use i	ccupation one during most of w etired)	orking	16b. Kind of Bu		
9	e filed withing Hygiene. other than	ပိ	17. Father's Name (First, Middle, Lest)		auto neci		me (First, Middle,	automo		epair
/lan	should be and Mental marked of umatic eve	To Be	George Winfield Dodson	n		Myrtle	e Estell	e Thom	as	
Man.			19a. Informant's Name/Relationship (Type, Print) Madolynne L. Dodson/wii		Meiling Address (Same as 10	reet end Number or F above	iurei Route Numbe	or, City or Town,	Stete, Zip C	ode)
imore,	permit. Peges 1 and 2 Department of Health s Important: If item 27 is any injury or other tra once.		20e. Method of Disposition  1 □ Burial 2 🗷 Cremetion 3 □ Removel from Stet  4 □ Donefion 5 □ Other (Specify)		Disposition (Neme of Carl Carl		Dete 5-15-99	20c. Location - Alexan		
Balt	permit. Pe Departmen Important: any Injury once.		21. Signature of Fundral Service Licensee			ddress of Fecility uneral Hor	ne, Port	Republi	c, MD	20676
	Physician /Medical Examiner	Je.	23. Part : Enter the disease, or complicetions that caus shock, or heart feilure. List only one cause on each immediate Cause (Finel disease or condition resulting in death)		ER CA		ac or respiratory ar	rest,	i in	pproximate iterval Between inset and Death
oʻ	ficate be executed physician and is the buriel-transit	Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying	Due to (or as a c	consequence of):					
x 68760,	certificate be ding physici se as the bu	/Medical	Ceuse (Disease or injury thet initiated events resulting in death) Lasf	Due to (or es e c	onsequence of):					
Box	death cert e attending ed for use	iclar	Part II Other eignificant conditions contributing to death	hut not consition to	the underbine enue	a shine in Rant I	ook Did a	-h	adelbuda da di	
P.O.	es that the death certification igned by the attending be detached for use a	/ Physician/M	Part II. Other eignificant conditions contributing to death  COPD B12 deficience	_	the unceriying caus	e given in Part I.		ree 2□ No		ne cause of death?
Division of Vital Records,	been s	Completed by						an autopsy med?	availe	autopsy findings able prior fo eletion of cause ath?
Ž	The law ate has page 2	Com					101	'ea 20 No	101	res 2□ No
Vita	ician: The certificate rector, pag	Be	25. Wes case referred to medicel examiner?			Other	eath (Check only o			
n of	Attending Physician: or death. ector: After this certific by the funeral director,	lon: To	1  Yes 2 No	jury 28b. T	ime of 28c.	Injury at Work?	Home 5 Resid	lence 8 Other		
Division	교육학교	Certification:	2 ☐ Accident Investigation 3 ☐ Sulcide 6 ☐ Could not be determined 28e. Place of I bullding.	28e. Place of Injury - At home, farm, street, factory, office building, efc. (Specify)				28f. Location (Street and Number or Rural Route City or Town, State)		
	To the Hospital within 24 hours of the Funeral completely filled	edical (	29a. Certifier (Check only one)  Certifying Physician: To the best and manner: on the basis and manner:	deeth occurred at the time, date end plece, end due to /or investigation, in my opinion, death occurred at the ti			and due to the cause(s) and menner es stated.  ad at the time, date and place, and due to the cause(s)		ed. e cause(s)	
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			30		D	36969		5/15/9	9	
	8		30. Name and address of person who completed cause of Scaria Mathew, M.D. 11			Rd., Lusby	MD 20	657		
	Sta Registr			strar's Signature	L	ha v.	, 110 20	<i>J</i> 1		



								ertificate of				Reg. No.	99	17214
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/Medica	ıl 🗀		STER		С.		EHR	ICK	4h	. City, Town, or Lo	MAY	8,19	7 1	0330
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Funeral		5. Social Security N		6. Sex	7.		last birthda	If Under 1 Yes		If Under 24 Hrs.	8. Date of Bi (Month, D	rth		thplece (State or Foreign buntry)
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238 0		A-9 MARIN	NER'S W	AY/HE	RRING	CREEK	K ESTS	. 19966				U	.S.A.	
		11. Maritel Stetus	· /	) A	Armed Force	ent Ever in U es?	J,S. 13	. Was Decedent o if Yes, specify Cu	of Hisp uban,	panic Origin? (Sp , Mexican, Puerto	ecify Yes or N Rican, etc.)	0- 14	. Rece - Ame Bleck, Whit	
nolicel Exerniner o	Dy F	1 ☐ Never Marri		ed 1	Yes 2 Yes, Give Year or Date	□ No		1□Yes 2XIN	No	Specify:		Si	pecify: WI-	HITE
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other traumatic event,	-	19a. Informant's Ne			Print)		19b. Me	iling Address (Stre	eet en			per, City or 1	Town, Stele,	Zip Code)
or trac		MARK E. E						OAKVIEW						
8	1	20a. Method of Disp		2 Domo	val fram Ct		cemetery, cr	oosition (Neme of emetory or other p	plece)		Date	100	ition - City or	Town, State
		4 Donation			vei iloili Sii	ME	LSON'	S CAPE HE	ENL	OPEN (	05-12-9	9 FR	ANKFOR	D, DELAWARE
any Injury or		21. Signature of Fu	netwi Serviced	Merisaa /	1			22. Name end Add			VICES.	LTD.		
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		23a. Part1. Enter the shock, or hear	rt failure.	complication only one ce	ns that cau	sed the dea th line.	th. Do not e	nter the mode of d	dying,	, such es cardiec	or respiretory	arrest,		Approximete Intervel Between Onset and Deeth
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er		diseese or condition resulting in deeth)	n	8		Due to (	or es e cons	equence of):						4/27/99
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as me bi	Physiciarymedica	resulting In deeth) I			n	50V	or as e cons	equence or).			,			YAS
5	ary			d		700				_				.,,,
should be detached for use	SICI	Pert II. Other stgnifi	icant conditto	ns contribu	ting to deat	h but not re	sulting in the	underlying cause	given	n in Pert I.	23b. Dic	l tobacco us	se contribute	to the cause of death?
i	E										10	Yes 20	No 3□P	robably 4 Unknow
3	d Dy										24e. We	s en autops	y 24b.	Were eutopsy findings
	Completed											omed?		eveileble prior to completion of cause of death?
	E										10	Yes 20	No No	1 Yes 2 No
5	2	25. Wes case refer	red to medicel						-:	26. Piece of Deal	th (Check only	one)		
	2	exeminer?		Hospi	1,88 Inp		] ER/Outpati	ent 3LI DOA	Other	4 U Nursing Ho			-	ecify)
	27. Menner of Deeth 28e. Dete of Injury 1 Month, Dey Yeer) 28b. Time of thijury et Work? 28d. Describe how injury occurre Work?								occurred					
	Car	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be 299 Place of Javes A home form short factors of the could not be							Number or A	Tural Route Number,				
	Ceruncation:	4 Homicide determined determined determined building, etc. (Specify)												
completely filled in by the funeral director, pege 2		29a. Certifier (Check only one)	1 Certifyin 2 Medical I	Examiner:	n: To the be On the besi	s of examin	owledge, de etion end/or	eth occurred at the investigation, in m	e time	o, dete and plece, nion, deeth occur	end due to the red et the time	cause(s) a , date and p	nd menner a lece, and du	s steted. e to the cause(s)
To the Funeral Director: After completely filled in by the fune		29b. Signature and	title of certifier			1		29c. Lice	ense i	number		29d. Date	signed (Mon	th, Day, Year)
		10	p P	hin	bus	M		0	20	1912		5	18/	99
11		30. Neme and edd	ess of person	who comple	ted cause			1	1	- 1	/			
9/1		DENNIS J. 31. Dete filed (Man)	ChockNi.	CKI M	D 40	istrer's Sign	TEENS	HORE DRI	IVE	SALI	sbuny	md.	2180	4
State Registra		T.	AY 1 4	<b>199</b> 9	Sin	mer a	6	don	1	/				
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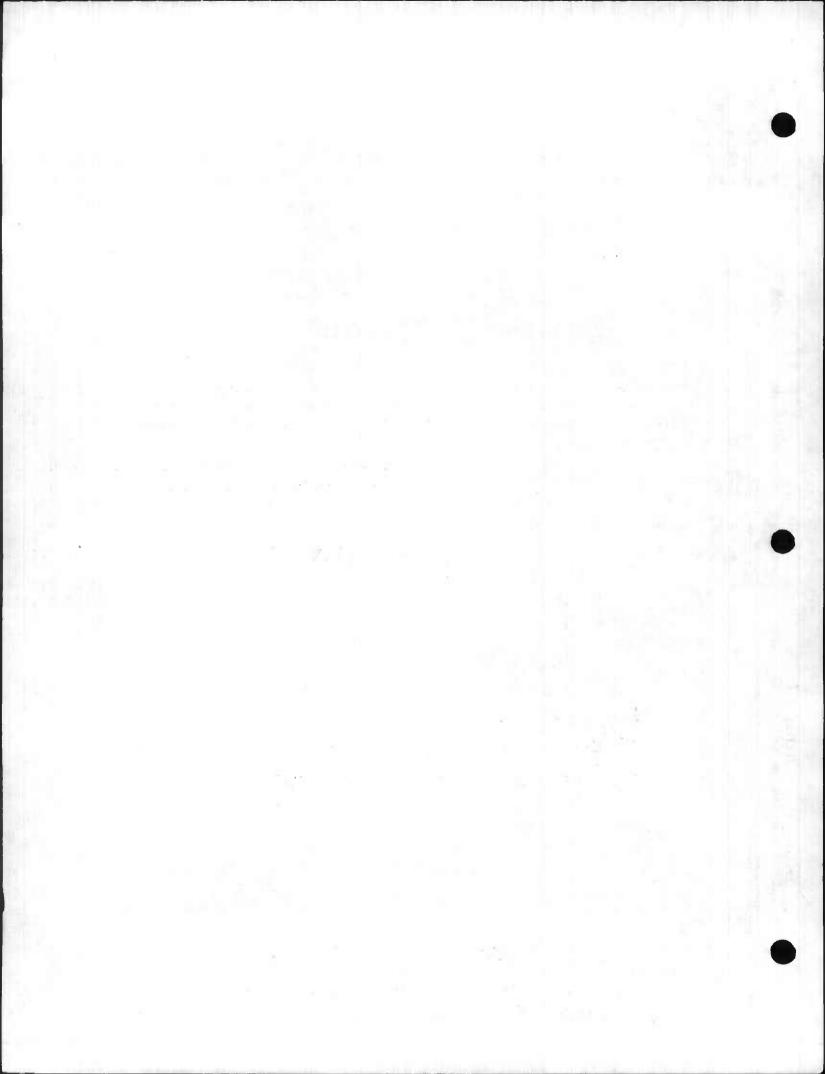
### Piease Type or Print in Biack Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death	h	Reg. No.	
Physicia	1. Decedent's Neme (First, Middle, Last)	2. Dete of De Month	Day Year	3. Time of Death
/Medic	Wilbur Louis Ellison	May 8,		2124
Examin		Town, or Location of Dealt	4c. County of Death	h
	1 Taylor Road Ris	sing Sun	Cecil	
Funeral Director	044-26-6780 15 M 2 F 64 Yrs. Months Days Hours	ler 24 Hrs. 8. Dete of Bin Min. (Month, Da November 4,	y, Year) Col	hplace (State or Foreign untry) ecticut
hend wo	Usual Residence of Decedent  10a. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits
Many Mary	Florida Pinellas Gulfport			1  Yes 2 □ No
Vith th	Florida Pinellas Gulfport  106. Street and Number  106. Zip Code		10g. Citizen of What Co	untry?
eb .	5205 Twenty Third Avenue South 33707		United State	
5-0020 72 hours after death with the Maryland natural', or items 23a or 28a-f show sicel Examiner must be notified at	5205 Twenty Third Avenue South  11. Merital Status 1 Never Merried 2 SMerried 3 Widowed 4 Divorced  12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 Sive Year or Dates:  13. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic If Yes, Sive Year or Dates:			
T c	15. Decedent's Education (Specify only highest grade completed)  Elementery/Secondery (0-12)  College (1-4or 5+)  8  16a. Decedent's Usual Occupetion (Give kind of work done during me life. DO NOT use retired)  Math Teacher	ost of working	16b. Kind of Business/I	E recent
d 212 flied withi Hygiene. rither than	8 Math Teacher		High School	1
yland 2 build be filed Mental Hygie arked other attic event, III	17. Fether's Neme (First, Middle, Last) 18. Mot	ther's Name <i>(First, Middle,</i>	Maiden Surname)	
laryia	19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Num	nber or Rural Route Number	er, City or Town, State, Z	(ip Code)
C = 0 F	Mary H. Ellison/ Wife 5205 Twenty Third Gulfport, Florida	Avenue Sout	h,	
or Healt Heart Hem 2	20e. Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location - City or 1	Town, Slata
Pege Pege mrt: Hill	1 Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify)  Brookview Cemetery	5/12/99	Rising Sun,	Maryland
Baitimore, pemit. Peges 1 at Department of He Important: If Hem. any Injury or other page.	21. Signature of Funeral Service Licensee  22. Name end Address of Fac Hicks Home for		P.A.	
	Some S. dicks 103 West Stock			
Physician	23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such a shock, or heart feiture. List only one cause on each line.	es cardiac or respiretory e		Approximete Interval Between Onset and Deeth
/ /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  a. CARD LAC ARREST			MINUTES
P #	Due to (or as a consequence of):  VOVTUCULAL RBRIC	LATION	1	MINUTEC
58760, leate be executed physician and s the buriel-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying  CORONARY ANTERN			
58760, icate be execut physician and s the buriel-trar	Cause (Disease or injury	DISTASE	F	YEARS
x 687 antificate ling phys	resulting in death) Last			
death certification				
P.O. Box ( the the death certified by the attending detached for use as	d  Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Per	ort I. 23b. Did	tobacco uee contribute	to the cause of death?
s that the igned by the be detached		1	Yee 2507No 3□Pr	obably 4 Unknown
Records,			rmed?	Were autopsy findings available prior to completion of cause of death?
The leave the page 2		10	Yes 2 No	I □ Yes 210 No
f Vital Royalcien: The Los certificate he director, page	25. Wes case referred to medical 26. Pla	ace of Deeth (Check only,	one)	Residence
O f 57	O 1 Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4	Nursing Home 5 Resi		
Vision Attending or death.	27. Menper of Death 28a. Dete of Injury 1 12 Neturel 5 Pending (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 1 2 Accident Investigation		now injury occurred	
Division To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	27. Menoe of Death 1 Neturel 2 Accident 3 Suicide 4 Homicide 2 Responsible to the property of	281. Location ( City or To	Street and Number or Ru vn, State)	ral Route Number,
To the Hospital or within 24 hours afte To the Funeral Dir completaly filled in	29e. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date of the control of the	end place, end due to the leeth occurred at the time,	ceuse(s) and manner es date end piece, end due	stated. to the cause(s)
To th To th comp	29b. Signature and little of certifier  BARRY WOHL  29c. License number  M.D.  D.2.	or	29d. Dete signed (Month	h, Day, Year)
	120 Ur M.O. D220	197 /	MAY 11,19	99
8	30. Name end eddress of person who completed ceuse of death (Item 23a) (Type, Print) 615 W. MACPHALL RD. SUITE 206 BELAIR	MANYUNG	21014	
Stat Registra	31. Date filed (Month, Day, Year)  32. Registrar's Signature			

ENTER PROPERTY.

# Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mantal Hydiana

		ate of Death	Reg.	2 9 9	17216	
Physician /Medical	1. Decedent's Name (First, Middle, Last) Treva V. Emmett		2. Date of Death Month May 16,	Dey Yeer 1999	3. Tima of Deeth	
Examiner	4s Facility Name (If not institution, giva street and number)  4b. City, Town, or L			ocation of Death 4c. County of Death		
W. L.	Sunrise Care and Rehabilitation	Elkton		Cecil		
Funeral Birector	166-40-8433 1□ M 2⊠ F 82 Yrs. Month		8. Data of Birth (Month, Day, Ye		hplace (State or Foreign puntry)	
pu ≱	Usual Residence of Decedent  10a. Stata 10b. County 10c. City, Town or Location				10d. Inside City Limits	
Sre, Maryland 21215-0020 st 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The marked other than "naturel", or farms 23a or 28a-f show other treumatic event, the Medical Examinations must be notified at To Be Completed by Funeral Director	Maryland Cecil Elkton 1□Yas 2ଔNo					
	10e. Street and Number 10f.	10f. Zip Code		10g. Citizen of What Country?		
	474 Blue Ball Road 21921			United States		
	1 ☐ Yes Give 1 ☐ Yes Year or Dates:	8. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □ Yes □ No Specify: White,  Specify: White		rican Indien, e, etc.		
	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  8  Clark	Decedent's Usual Occupation Give kind of work done during most of working ife. DO NOT use retired)  1erk  16b. Kind of Businass/Industry Retail Sales				
		18. Mother's Nan	ne (First, Middle, Mai		es	
ld be figured by the second by			e Bibler	T AT		
Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mentel thy important: if flow 27 is mericed othe any injury or other treumstic event page. To Be C		ess (Street and Number or Ru		City or Town, State, 2	Zip Code)	
		Ball Road, E				
	20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (from State Cherry Hill Methodist Ceremotery)	Vame of or other place)	Date 200	c. Location - City or	Town, State	
	21. Signature of Funerel Service Licensee  22. Nama and Address of Fecility Hicks Home for Funerals, P.A.  103 West Stockton Street, Elkton, Maryland 21921					
	23a. Pert1. Entar the disease, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line.  Approximate Interval Between Onset end Deeth					
/Medical Examiner	Immediata Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of the conse	auterit	z J		24 yrs	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours attending Physician: The law requires that the death certificate be executed within 24 hours attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit Medical Certification: To Be Completed by Physician/Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C. Due to (or es a consequence of the consequence of t					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23b. Did tobacco use contribute to the cause of death?		
	Alypetteusich		1 Yes 22 No 3 Probably 4 Unknown			
	Degenerative Arthritis		24a. Wes an a performed	n autopsy med? 24b. Wera autopsy findings available prior to completion of cause of death?		
	Congestive Heavy Faulure 10 yes 20 No 10 yas 20 No 25. Was case referred to medical 26. Place of Death (Check only one)					
	25. Was case referred to medicat axaminer?  1					
	27. Manner of Death 1 Natural 5 Pending investigation   28a. Data of Injury (Month, Day Year)   28b. Time of Injury   28c. Injury at Work? 2 Accident investigation   28a. Data of Injury   28b. Time of Injury   28c. Injury at Work? 1 Yes 2 No					
	3 Suicide 4 Homicide  Could not be detarmined  28e. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only nee)  1 Certifying Physician: To the best of my knowledge, deeth occurred at the tima, data end place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, date end place, and due to the cause(s) and menner stated.					
	20b. Signature and life of cartifier 29c, License number		29d.	29d. Date signad (Month, Day, Year)		
	XILLUST. DEC	4.20 1043148		5/17/99		
1	30. Name and address of person who completed cause of death (Nem 23a) (Type, Print)  James Ley, M.D. 412 Suburban Drive, N	Wewark, Delawa	re 19711			
State Registrar	MAY 1 8 1999 Aparts Signature	KN				



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** MATTIE FISHER 7. MAY 1999 6 PM 07 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NORTH HOSPITAL ANNE ARUNDEL ARUNDEL GLEN BURNIE If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 9. October 20, 1907 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign Country) 7 South Carolin 6 Sex **Funeral** Months 1 □ M 2 □ X 91 Yrs. Director 074-16-2882 with the Maryland 10a State 10h County 10c. City. Town or Location 10d. Insida City Limits "naturel", or items 23s or 28s-f show adical Examiner must be notified at MD 1 □ Yas 2 □ No Director Annrundell Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? se filed within 72 hours efter death wat Hygiene.
I other than "naturel", or flems 23a vent, the Modical Examiner must be 1818 Aberdeen Cir. 21114

13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puarto Rican, atc.) Funeral U.S.A. 14. Race - American Indian, 12. Was Decedent Evar in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Yaar or Datas: 1 Nevar Marriad 2 Married Saltimore, Maryland 21215-0020 Black 1 ☐ Yes 2 ☐ No Specify: Specify þ 3 □ Widowad 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Nurse 7 is marked other traumatic event, i 18. Mother's Name (First, Middle, Maiden Surnama) 17. Fathar's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental | Raliegh Thomas Minnie Rogers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a H Hem 27 Is or other tra Robert K. Fisher 1818 Aberdeen Cir., Crofton, MD 21114 20a. Method of Disposition 20b. Place of Disposition (Neme of camatary, crametory or other plece) Data 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or page. 4 ☐ Donation 5 ☐ Other (Specify) Sandy Grove Church Cemetery5/14/99 Lamar, SC 22. Name and Address of Facility Johnson & Jenkins Inc. 21. Signature of Funaral Sarvice Licensea 716 Kennedy St., NW, Washington, DC 20011 23a. Part1. Enter the disaasa, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onsat and Death **Physician** /Medical Immediate Cause (Final MYOCARDIAL INFARCTION 1 hour disaase or condition resulting In death) Examiner Due to (or as a consaquenca of): Examiner DIABETES MELLITUS 25 years The law requires that the death certificate be asscuted Sequantially list conditions, if any, laading to Immediata cause. Entar Underlying Cause (Diseasa or Injury that Initiated evants resulting in death) Last Due to (or as a consequenca of): physician east the buriel-t 25 years Box 68760 HYPERTENSION Physician/Medicai Due to (or as a consequenca of): 65 for usa as 25 Vers HYPERLIPIDEMIA 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. per per signed by the 1 Yes 2 No 3 Probably 4 Unknown DIVERTICULOSIS Division of Vital Records. à 24b. Wera eutopsy findings available prior to 24a. Was an autopsy Completed ARTHRITIS completion of cause of death? certificate hes blirector, page 2 s 1 Yes 2 No PERIPHERAL VASCULAR DISEASE 1 ☐ Yes 2 ☐ No Hospital or Attending Physicien: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatiani 2 ☐ ER/Outpatient 3 ☑ DOA Certification: To this funeral 28a. Date of injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Natural 5 Panding Invastigation death. 1 Yes 2 No 2 Accidant after death 6 Could not be datarmined 3 Sulcida Location (Street and Number or Rural Route Number, City or Town, State) 28a. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida To the Hospital or A within 24 hours after To the Funerel Dire completely filled in b 29a, Cartifiai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end placa, and due to tha causa(s) and mannar as stated. edicai 2 Medical Examinar: On the bests of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Licanse number 29d. Data signed (Month, Dey, Year) 29b. Signatura and titla of certifier D50343 un 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) SUITE A-6 BOWIE I MARYLAND 3231 SUPERIOR KELVIN HAO LANE 31. Date filed (Month, Day, Year) 32 Ragistrar's Signature State MAY 1 2 1999 Registrar

560, 2 · An

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. Amend Item 1, 5/18/99, bam Department of Health and Mental Hygiene Certificate of Death Cecil Co 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Shannon Marie Foster 2. Date of Deeth **Physician** Jhannonm toster 16:14 5 15 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not Institution, give street end number) **Examiner** Baltimore N/A RAdams Conley Shock Trauma Center 7. Age (In yrs. last birthdey) If Under Months If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey. Year) 5. Sociei Security Number 6. Sex Birthplece (State or Foreign Country) **Funeral** 1□ M 2X F Days Yrs. 15 217-21-6617 Nov. 14, 1983 Director Maryland Usuel Residence of Decedent deeth with the Maryland ital Hygiene. In other than "natural", or frems 23s or 28s-f show avent, the Modical Examinet must be notified at 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 20 No Director Colora Maryland Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 13 Pleasant Drive 21917 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Race - American indien. 11. Merital Status Bleck, White, etc. hours efter 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: p 3 Widowed 4 Divorced White Completed 16e. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 72 Elementery/Secondary (0-12) College (1-4or 5+) Public Schools Student 10 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If flem 27 Is marked other any Injury or other traumatic avent, place. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Pauline Marie Edwards Jesse M. Foster, Jr. 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Jesse M. Foster, Jr./Father 13 Pleasant Dr. Colora, MD 21917 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 N Buriai 2 ☐ Cremation 3 ☐ Removal from State Christ Community Fellowship 5-19-99 4 ☐ Donation 5 ☐ Other (Specify) West Grove, PA 21. Signature of Funerel Service Licenses 22. Name and Address of Facility R. T. Foard Funeral Home, P. A. 111 S. Queen St., Rising Sun, MD 21911 ichara 23a. Per I Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, show, or heart failure. List only on cause or mady line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finei Multiple Traumatic Injuries diseese or condition resulting in deeth) Examiner Due to (or es a consequence of): Examiner Vehicle Cras 2 hours and Il-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last Due to (or as e consequence of): physician ar Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or es a consequence of): PROVED BY MEDICA ettending p signed by the e 23b. Did tobacco use contribute to the cause of death? Part ii. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings eveilable prior to completion of cause of death? should ! Completed 24e. Wes en eutopsy performed? is certificata has t director, page 2 s 2 No 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical Be 28. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Yes 2 No 1 inpatient 2 2 ER/Outpatient 3 DOA this Aftar this funeral 27. Menner of Deeth Dete of Injury (Month, Dey Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred Certification: 337 P 5 Pending investigation 1 Naturel 5/15/99 1 Yes 2 No Moter Vehicle Crash death. after death Director: / d in by the f 2 Accident 3 Suicide 6 Could not be determined 281. Location (Street end Number or Rural Royte Number City or Town, Stete) Plece of Injury - At home, fe building, etc. (Specify) 4 \ Homicide Love Dun Rd. + Co To the Hospital or within 24 hours aft To the Funeral DI completely filled in word 1 Certifying Phyalcien: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and menner as stated.

| Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) edical 29a. Certifier (Check only one) and menner stated 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Attending 04614 Withaul (Sin, M.D. Suzeon 30. Name and eddress of person who completed cause of deeth (item 23e) (Type, Print)

Shock Trauma Center, Baltimore, mo 21201

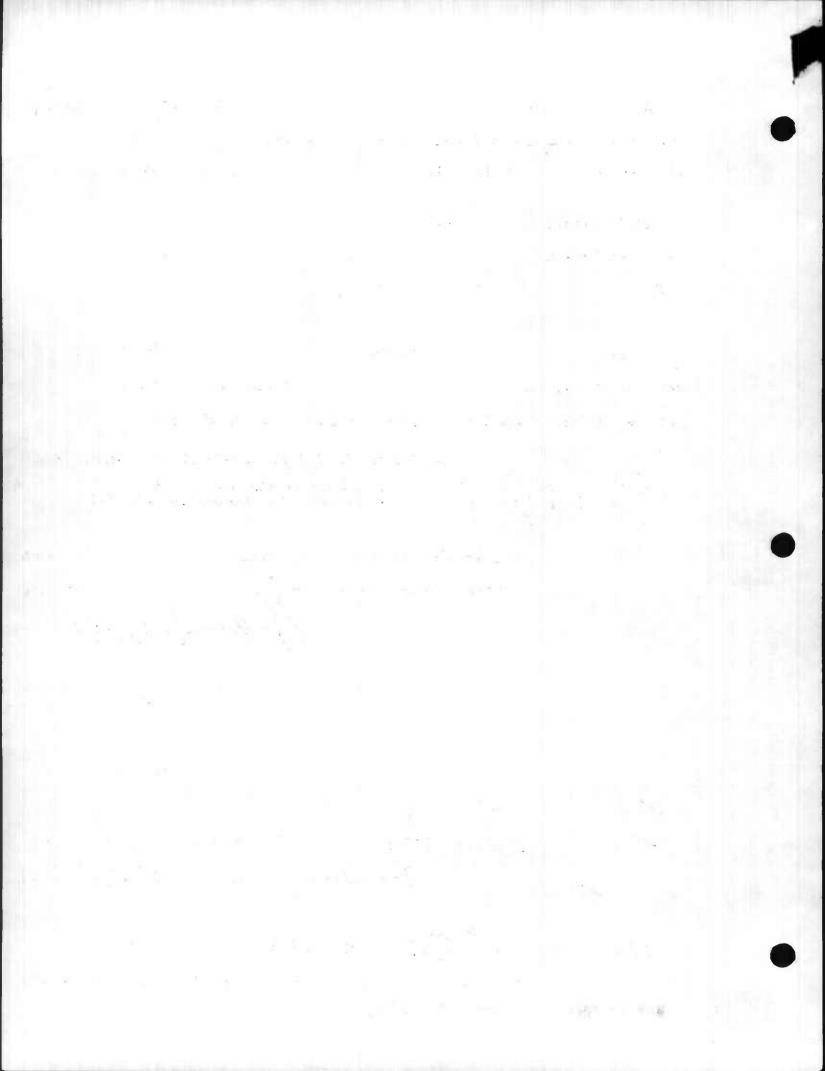
State Registrar 31. Dete filed (Month, Dey, Year)

MAY 1 8 1999

William C. Chin, m.D., R Adens Cowley

32. Registrer's Signature

3



	-				State	IVIQ	il ylallu /		tificate of	Death		Reg. No.		1213
	Physicia	ın	1. Decedent's Nat VFR	me <i>(First, Middl</i> e ONICA	D.	GLE	7NI				2. Date of Do Month May 4	Day o	Yaar	3. Time of Death 9:36 PM
ίο.	· /Medic	al			giva straat end nu		214			4b. City, Town, or I			of Death	9:30 PM
2	Examin	er			entist Ho		+-1							
	Funeral Director		5. Social Security	Number	6. Sax		(In yrs. lest	birthdey). 8 Yrs.	If Under 1 Year Months Days	Takoma P If Under 24 Hrs. Hours Min.	6. Data of Bi	Montg	9 Right	y Nace (State or Foreign SOUTH Ana, America
	pue *		Usuai Residence 10a. State	of Decedent  10b. County			10c. City, T	own or Loc	cation				1	Od. Inside City Limits
	4 sho	Por	MD		Georges		•	tsvil						1 Yes 2 □ No
	or 28a	Director	10e. Street and N	umber					10f. Zip Code			10g. Citizen of V	Vhat Coun	itry?
	23a		7966 Rig	ggs Road						783		U.S.		
020	72 hours effer death with the Meryland hastural", or flems 23a or 28a-f show geal Examiner must be notified at	by Funeral		rriad 2∰ Marri 4 □ Divorced	12. Was Dec Armed Fo 1 ☐ Yas If Yes, Gi Year or D	orces? 2 1 N ive			Vas Decedent of the Yes, specify Cub	Hispanic Origin? (S ean, Mexican, Puart Specify:	Specify Yes or N to Rican, etc.)	o- 14. Race Blace Specify	k, White,	
2-0020	n 72 hours natural', ed cal Ex	eted	(Spe	15. Decedent	s Education	)	1	6a. Deced	ent's Usual Occu	pation during most of world)	rkina	16b. Kind of Bu	sinass/Ind	dustry
7	e 4 20	Completed	Elementary/Sec		College (		41	life. D Homem		nd)		N/A		
7	filed within Hygiene. ther than	S	17. Fathar's Name	_	ast)			Homen		18. Mothar's Nar	me (First, Middle	e, Malden Sumem	e)	
/land	should be filed within nd Mental Hygiene. marked other than Imatic event, on Me	To Be	Joseph	Withers	spoon					Pamela	(unknow	vn)		
lary	should be man		19a. Informant's i					19b. Mailin	g Address (Strea	t and Number or Ru			Stete, Zip	Code)
e,	end m 27 her tr				Daughter	r			LaPlata sition (Nama of	st., Si				04-4-
pairimor	permit. Pages 1 and 2 should be filed within Department of Health end Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Mones.				3 □Removal from ecify)	State	ceme	etery, crem	shington	Cem.	Data 5-13-99	Adelphi		wn, State
50X 68/60,	Physician produced be executed and increase the burial-transit produced to the produced by the	nn/Medical Examiner	Immediate Cause disease or condit resulting in daath  Sequentially list of any, laading to cause. Entar Um. Cause (Disease of that initiated avan resulting in death	a (Final ion )  conditions, immediata derlying or injury its	a. M.A.  b. C.  d.	eplen	Due to (or as	a consequence a consequence	uance of):	ng, such as cardial  NA60 v  Dodo S		arrest,		Approximata Interval Batween Onsat and Death
5	the ette	sick	Part II. Other algr	nificant condition	s contributing to d	leath bu	it net resultin	g in the po	derlying cause g	iven in Part I.	23b. Dio	tobacco usa soi	ntribute to	o the cause of death?
7.	thet the	P	1 M	2885	c Pe	D	2y	Pd	dema	npto	1	Yes 2N No	3 Pro	bably 4 Unknown
cords,	To the Hospital or Attending Physician: The law requires that the deeth certif within 24 hours after death.  Within 24 hours after death.  To the Funcatal Director. After this certificate has been signed by the ettending completely filled in by the funeral director, page 2 should be detached for use e	Completed by Physician/M	CO N	anst )	line.	0	) &	NCR	C An	Umia	24a. Wa	s an autopsy formed?	av	are autopsy findings aliable prior to impletion of cause death?
ב	The la	E	(G) HI	9 GOA	a control						1□	Yas 2 No	10	□Yas 2□No
2	entifice sctor, p	Be	25. Was case refe examinar?	erred to medical				^		26. Place of De	ath (Check only	one)		
5	shysic this co	ို	1 Yes 2			Inpatie		/Outpatien	3LI DOA			sidence 6 Oth		(ע
5	ding h. After funer	ti ou u	1 Natural 2 Accident	5 ☐ Panding invastig		ith, Day	Yaar) 20	b. Time of Injury	28c. Inju Wo M 1	ork? ]Yas 2 □ No	280. Describe	how injury occur	90	
DIVISION	I or Attending Physician: efter death. Diractor: After this certification by the funeral director,	Certification:	3 Sulcida 4 Homicide	6 Couid n	ot be 28e. Place	e of Inju ling, atc	iry - At home :. (Specify)	, farm, stre	eet, factory, office		28f. Location City or To	(Street end Numb own, Stete)	er or Rura	al Route Number,
	To the Hospital or within 24 hours effe To the Funeral Dir completely filled in	edical C	29a. Certifier (Check only one)			asis of	examination			ima, data and piace opinion, death occu				
	To the To the comp	M	29b. Signature an	titla of certifier	ned A	. N	ran	NGN	MD 29c. Lican	se number 4593		29d. Date signe	d (Month,	Day, Year)
	(2)		110717	10.(11.14				, ,	Park. D. >	3331 244A	1-101 TTSV		MI	LRACE 2, 20782
	Sta Registra		31. Date filed (Mo	nth, Day, Year) 1 0 1999		Registra	r's Signatura		R.					
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Registrar DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene

ANNA								S	tate	of Ma	ryland	Department of Health and M
GOZIK	ITEMS:	#23	PART	I,	II,	27,	28A-F	PER	MEO	G772	6-2-99	We Certificate of Death

SIK TIEMS: #2		PART I, II, 27, 28  1. Decedent's Nama (First, Mic			6//2	0-2-99	w Cei	titicat	e of	Death		2. Date of D			3. Time of Death
Physicia /Medica	_	Anna Go	zik									MAY	06, Day 199	99 Year	9:40 PM.
Examine		4e Facility Name (If not institute ST. AGNES HO			number)							ocation of Dea MORE	th 4c. Cour	ity of Death	
Funeral Director	2	5. Social Security Number 233–52–1768	6. S	Sex I□M 2HXF	7. Ag	e (In yrs. las	t birthday) Yrs.	If Under Months	1 Year Days		24 Hrs. Min.	8. Data of B (Month, D Jan. 2	irth (1919	9. Birth Cou West	place (State or Foreign intry) Virginia
with the Maryland a or 28a-f show Lbs notified at		Usual Residence of Decedent 10a. State 10b. Cour MD	ty			10c. City, 1 Balt	imore								10d. Inside City Limits XXX Yes 2 □ No
th with the 23s or 25s unt be not	I Director	10e. Street and Number 1 Kenwood Aver	nue					10f. Zip	Code 228			724	10g. Citizen d USA		intry?
herra herra ber.m	by Fur	11. Marital Status  **Never Merried 2 M 3  Widowed 4 Divorce		Armed 1 U Ye If Yes,	Forces?	Ever in U,S. No		Wes Deced I Yes, spec				ecify Yes or N Rican, etc.)	Spec	lack, White	ican Indian, , etc. Thite
Maryland 21215-0020 of 2 should be filed within 72 hours at the and Merital Hygleno. The marked other than "natural", or traumatic event, the Medical Exam	Completed	15. Deced (Specify only high Elementery/Secondary (0-12	nest gra	de complete	od) e (1-4or 5		(Give life. L	lent's Usue kind of wor DO NOT us emake	rk done se retire	pation during mos ed)	t of work	sing	16b. Kind of Own. H		ndustry
yland build be file Mental Hy arked othe aftic event,	To Be C	17. Father's Name (First, Middle Michael G. Go								18. Moth			e, Maiden Sum	ame)	
		19a. Informant's Name/Relation Mary Hrutkay/S 20a. Method of Disposition					l Ken		Ave			imore,		1228	
Baltimore, semit. Pages 1 ar Department of Nes iny injury or othe interior.		1 Burial 2 Cremetion 4 Donation 5 Other	(Specif)	y)	om State	cem	etery, cren	I.O.	O.F	. Ceme	1	y 5/13/	20c. Location 99 Rose		
Dem Depa Impo		21. Signature of Funeral Service	/	1/8	2		44	3 Wes	t P	ike S	Da tree	t, Cla	neral Horksburg		26301
Physician /Medical Examiner	ner	23a. Pari 1. Enter the disease, shock, or beart feiture. Ut Immediate Cause (Finel disease or condition resulting in death)	St Only		HEAD A	ND NECK	INJUF	RIES			į			\$ \$ \$ \$	triterval Between Onset and Death
K 6876( antificete be ing physicia as the bur	Med	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	{	c		Due to (or as								1 1	
D. O. B	2	Part II. Other significant condi								ven in Pert	l.		tobacco use		to the cause of death?
0 : 5.2	Completed by	NITE (TENSAVE )		TOSCEN	OTIC	CANDIOV	A3COCF	N D131	, AJL			24a. Wa	s an autopsy formed?	a	Vere autopsy findings vailable prior to completion of cause of death?
- F 44 6	0	25. Was case referred to media	al							26 Place	a of Doot	1 €	Noc 2□ No		Övres 2□ No
of Vita Physician: this certificant director,	0	examiner? 1\(\times\) Yes 2 \(\times\) No		Hospitet:	☐ Inpatie	nt 2DER	/Outpatien	t 3 DO	A O	hor			sidence 6 DC	ther (Spec	ify)
Vision Attending death. ctor: After y the fune		3 ☐ Suicide 6 ☐ Coul	tigation	28a. Da (MAY	te of Injur ionth, Day 4, 19		b. Time of Injury	р 2 м		iryat ork? ]Yes 2 ⊠	No	28d. ['escribe	chair, Di	ED 2 D	DALL LATER  AL LATER  AND ROUSE NUMBER,  NOLLS NURSING
		29a. Certifier 1 Certify (Check only 2 Medic	ing Ph	ysician: To t	NUR he best of basis of	s. (Specify) SING HO of my knowle examinetion	ME dge, death	occurred	at the ti	ime, date en	id place,	HOME 22		E. BAL	TIMORE, MD.
To the To the comple	Σ :	296. Signature and title of certification	ier	and mi	enner sta	ted.	_	290	. Licen	se number			29d. Date sign		, Day, Year)
(4)		30. Name and address of personal from NE (1) (31. Date filed (Month, Day, Yes	Kin	9		111	l Pen		eet	, Bal	timo	re, Mai	ryland 2	21201	
State Registra	•	MAY 1 1 1		3	Thought I	r's Signatura	4.	loon	de	,					

DHMH 16 Ray 6/95

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	3.5	LL	AMND: ITM#4a,10e,					Death		Reg. No.	9	17221
ı	Physic	ian	1. Decedent's Name (First, Mic						2. Deta of Da Month	Day	Yaar	3. Tima of Death
d	/Medi		CORNELL GRICE  4a. Facility Nema (If not institut		mharl			4b. City, Town, or L	MAY		99	3:45 a.m
4	Exami	ner	2008 Hannon St								y of Deeth	
H	Francis	-	5. Social Sacurity Number	6. Sax *	BERKSHIRE 7. Aga (In yrs.		If Under 1 Yaa	Hyattsvi				orges
à	Funeral Director		240-26-1668 Usuei Rasidance of Decedant	1 <b>X</b> □M 2□F		O Yrs.	Months Days	Hours Min.	8. Data of Bir (Month, Da MAY 5,	1919	NORTH	pleca (Stata or Foraign ntry) I CAROLINA
	yland		10a. Slata 10b. Cour	ity	10c. Ci	ty, Town or Lo	cation					10d. insida City Limits
	a-f si	tor	MD Prin	ce Georges	Hv	attsvil	1e					1□ Yes 2□ No
	or 28	Director	10e. Straat and Number	200		4000	10f. Zip Coda			10g. Citizan of	Whet Cou	
	23a		2008 Hannon S	treet 824	BERKSHIR	E DRIVE	2078	3		U.S.	A	
	er de	Funeral	11. Marital Stetus	Armed Fo		l,S. 13. V	Vas Dacedant of Yas, specify Cul	Hispanic Origin? (Sp ben, Maxican, Puarto	ecify Yas or No Rican, etc.)	- 14. Ra	ce - Amari	can Indian,
020	72 hours after death with the Maryland "natural", or items 23a or 28a-f show local Examiner must be notified at	by F	1 ☐ Nevar Married 2 ☑ M 3 ☐ Widowad 4 ☐ Divorc	If Vas Giv	2 □ No /a alas:		☐ Yes 2 No				<sup>fy:</sup> Bla	
21215-0020	72 hor		15. Deced	ant's Education		16a. Deced	ent's Usuei Occu	pation		16b. Kind of B		
21	S	Completed	Elementary/Secondary (0-12	hast grada completed) 2) College (1	-4or 5+)			rpation a during most of work ad)	ring			
121	73 73 4		12th			Fo	od Serv				rnmen	t
Maryland	S d ab >	Be	17. Fathar's Nama (First, Middl	e, Last)				18. Mothar's Nam			ma)	
Z	should b ind Mente marked	2	Percy Grice	nehin (Tyne Print)		10h Mailin	a Addrage /Ctrae	at and Number or Rui			State 76	Code
Ma	2 6 6 6		19a. Informent's Name/Raiatio GR Marie <del>Cr</del>					St., Hyan				
re,	of Haalth Item 27 other tr	:	20e. Malhod of Disposition		20b. F	Place of Dispos	sition (Nama of atory or other ple	oc., nyai	Data	20c. Location	20783 - City or To	
E	Pages nent of h int: if its		1 ☑ Burial 2 ☐ Cramation 4 ☐ Donation 5 ☐ Other				oln Cem	etery !	5/15/99	Brentwo	ood,	MD
Baltimore,	permit. Pages Department of Important: If I eny Injury or 2005.		21. Signatura of Funarai Sarvic	e Licensee		22.	Nama and Addr	and the state		& Jenki		
00	82 = 8		Delna	Index.	B-	716	Kenned	y Street,				
			23a. Part1. Entar tha disaase, shock, or heert feilura. Li	or complications that coist only one cause on e	aused tha daat ech lina.							Approximeta Interval Between
	Physician							-			1	Onsat and Death
	/Medical Examiner		Immediate Ceusa (Final disaasa or condition rasulting in daath)	aF	Renal F	ailure						3 weeks
		ē	,			or as a consequ						0 0
	uted d ansit	Examiner	Conversion to the same distance	b		Cancer or as e consequ	-metast	atic	_			2-3 years
ó	tificate be axecuted ig physician and as the burial-transit		Sequantially list conditions, if any, leeding to immediata causa. Entar Underlying Cause (Disaasa or injury		Dua to (c	as e consequ	ance ory.					
68760,	ate be hysici	edical	Cause (Disaasa or injury that Initieted avants rasulting In daath) Lest	C	Due to (o	r as e consequ	ence of):					
	± 0 €		, and a second s	d								
Box	that tha death cered by the attendir detached for use	Physician/M		0								
P.O.	ha de / the a	ysic	Part II. Other significant condi-	tions contributing to de	ath but not res	uiting in tha un	darlying causa gi	van in Part i.	23b. Did	lobacco uee co	ontributs to	o the cause of death?
	requires that tha death cer seen signed by the attendir hould be detached for use								1 🗆	Yss 2 No	3 ☐ Pro	bably 4 Unknow
Records,	puires n sigr uld be	od by							24e. Was	an autopsy		ara autopsy findings
000		ojete							perfo	rmed?	co	railabla prior to empletion of cause death?
Ä	The law ata has b page 2 s	Completed							10	ras 2⊠ No	1111	☐ Yas 2☐ No
ā		BeC	25. Was casa rafarred to medic	ai				28. Pieca of Deat			1	2,440
<u>&gt;</u>	Physician: r this certific rral director,	To	examiner? 1 ☐ Yas 2 ☐ No	Hospital: 1 ☐ Ir	npatiant 2	ER/Outpatient	3□ DOA Ot	her: 4 Nursing Ho	ma 5 Resid	dance 6 DOth	nar (Specif	5)
n o	ding Pl h. After ti funera	ou:	27. Mannar of Death 1 □Naturei 5 □ Pano		of Injury h, Day Year)	28b. Time of Injury	28c. Inju Wo		28d. Dascribe I	now Injury occur	rred	
Division of Vital	Attending or death. Sector: After by the fune	cat	2 Accidant invas	d not be	-61-1 4-1			Yas 2□No	oof Leastine (	34		10. 11.
<u>&gt;</u>	or Attendation of Director:	Certification:	4 ☐ Homicide data		of injury - At no		at, factory, office		City or To		oer or Hurs	al Route Number,
	spital nours nerai		29a. Certifier 1☑ Cartify	ring Physician: To tha	bast of my know	wiadge, death	occurred at tha ti	me, dete end place.	and due to the	cause(s) end m	ennar as s	taled
	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completaly filled in by the funeral	edlcai	(Check only 2 Medica	i Examiner: On the ba and mann	sis of axamine	tion and/or inve	astigation, In my	opinion, daath occur	red et tha time,	data and place,	end due to	tha cause(s)
	To the To the Com	Σ	29b. Signature and title of certif	(Yes			29c. Licen	se number		29d. Data signe	ed (Month,	Dey, Year)
	(~)		x (Ille)	10cm	141			19069		5/:	11/99	
1			30. Neme and address of perso							7		
1	/		Allan S. Roy 31. Dete filad (Month, Day, Yea	gers MD 10			tol St.	, NE, Wash	nington	, DC 20	0002	
	Sta Registr		MAY 1 2 19		egistrar's Signe	<b>B</b>	loveto	,				
						_	THE THE					

DHMH 16 Rev 6/95

PERIS L YAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

if Undar 1 Year

10f. Zip Coda

21545

1 ☐ Yas 🏖 No Specity:

Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired)

Deys

7. Age (In yrs. last birthdey)

86

12. Was Decedent Ever in U,S. Armed Forces?1 Yes, 2 No If Yes, Give Yaar or Dates:

Coilege (1-4or 5+)

Yrs.

10c. City, Town or Location

MT. SAVAGE

HOUSEWIFE

2. Dete of Death

8. Dete of Birth (Month, Dey, Year)

Dey

USA

10

Month

MAY

4b. City, Town, or Location of Deeth

CUMBERLAND

If Undar 24 Hrs.

Wes Dacadent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puerto Rican, atc.)

	Funerai Director	
Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, its Medical Examiner must be notified at other.	To Be Completed by Funeral Director

**Physician** 

/Medical

Examiner

1. Decedent's Neme (First, Middle, Lest)

5. Sociei Security Number

213-22-3598

Usuei Residence of Decedent

10e. Street end Number

11. Maritei Status

8

10e. State

ERMA MARIE GLASS

4a. Facility Neme (If not institution, give street end number)

10b. County

12815 NEW ROW ROAD NW

15. Decedent's Education (Specify only highest grade completed)

MARYLAND ALLEGANY

1 Never Marriad 2 Merried

3€ Widowed 4 Divorced

Elementery/Secondery (0-12)

17. Fether's Neme (First, Middle, Last)

CUMBERLAND NURSING HOME

1 M 2 F

e e						IE PKE		
Is marke raumatic	2	19e. informant's Neme/Reletionship	(Type, Print)	19b. Mailing Add	ress (Street end Number or	Rural Route Nur	nber, City or Town	, Stete, Zip Code)
r tra	-	PASTOR JAMES G	LASS/SON	12816 N	T. SAVACE	ROAD N	W.MT. S	AVAGE, MD2154
or other traumatic	ľ	20e. Method of Disposition		20b. Piece of Disposition (	Neme of	Date	1	- Clty or Town, Stete
y or		1 DaBuriel 2 ☐ Cremetion 3 4 ☐ Donation 5 ☐ Other (Spec		TEMPLE CEN		MAY		
ulu a		N. Signeture of Funerel Service Lice	**		a and Address of Fecility	14,199	9 MEYER	RSDALE, PA
any Injury o	- 1	Olgitolata di Fariera del vida Elo	011300			HOME		
		Douglas	a l. Hope	1302	NATIONAL	HWY, L	AVALE, M	ID 21502
ician		23a. Part1. Enter the disease for conshock, or heart feilure. List only		A		iec or respiretory	arrest,	Approximate interval Batween Onsat end Death
dicai		immediate Cause (Final disaasa or condition	Carona	y Arten	Discare			joyean
niner		resulting in daath)	e. Du	e (or es a consequence	of):			
	Je.			<b>9</b> (0. 00 2 00.00400.00	0.7.			
prysician and the buriel-transit	Examiner	Sequentially list conditions	b	e to (or as e consequence	of)·			
		Sequentielly list conditions, if eny, leeding to Immediate ceuse. Enter Underlying		10 (01 20 0 0011004101100	0.7.			
e pr	ca	Ceuse (Disease or injury that initiated events	C	to (or es e consequence	M.			
as th	8	resulting in deeth) Lest		to (or ea a consequence	J1).			
for use as t	2		d					
d for	Cla							1
		Part II Other significant conditions	appetally stime to stooth but a	at annual to a terminate of	a cours about to Don't	OOL DI	1 d d a b	
ache	hysi	Part II. Other significant conditione	1	ot resulting in the underlylr	g ceuse given In Pert I.			ontributs to the cause of death?
a detached f	Phy	A	1	ot resulting in the underlylr	g ceuse given In Pert I.		d tobacco use co	ontributs to the causa of death?  3 Probably 4 Unknow
5 00	P	A	1	ot resulting in the underlylr	g ceuse given In Pert I.	- 11		3 Probably 4 Unknow
5 00	P	Part II. Other significant conditions Drahetes Me Dementia	1	ot resulting in the underlylr	ig ceuse given in Pert I.	1 { 24e. W	□ Y## 2 No	3 Probably 4 Unknow  24b. Were eutopsy findings available prior to completion of cause
ge 2 should be d	P	A	1	ot resulting in the underlylr	ig ceuse given in Pert I.	1 { 24e. W	Yss 25 No	3 Probably 4 Unknow  24b. Were eutopsy findings available prior to
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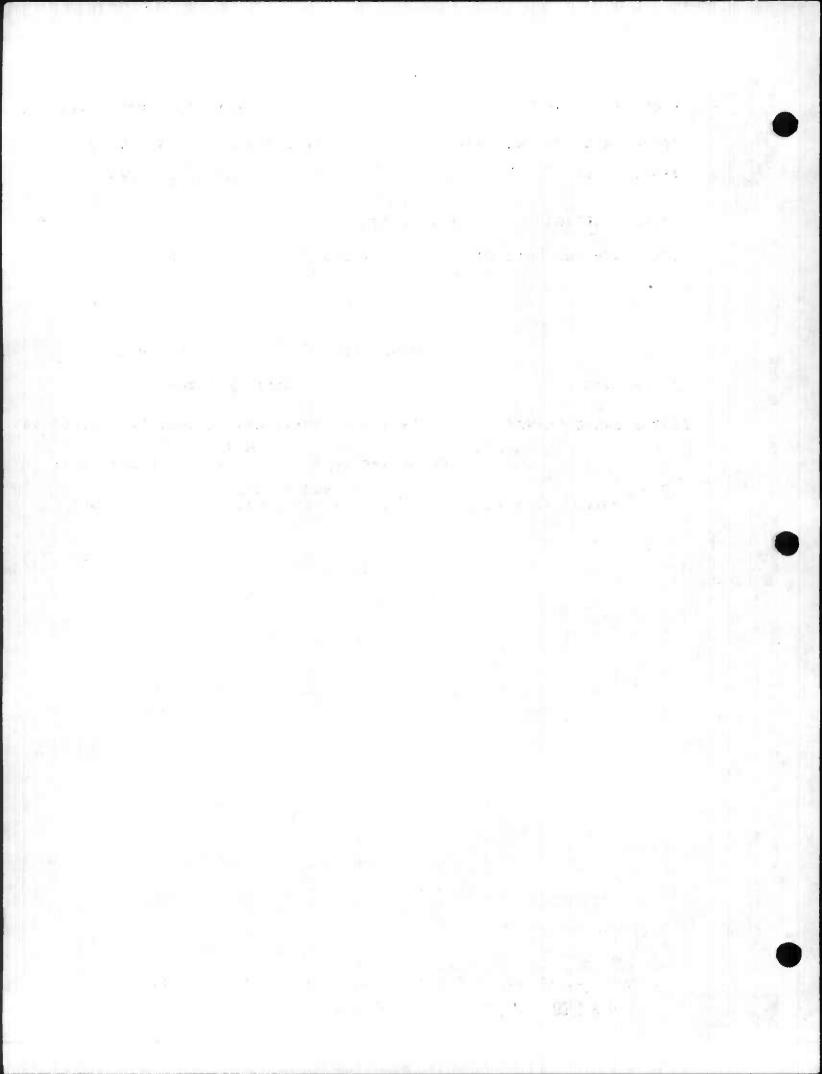
3. Time of Death 1999 10:15 PM 4c. County of Deeth ALLEGANY Birthplece (Stete or Foraign
Country) OCT 4,1912 KENTÚCKY 10d. Inside City Limits 1 Yes No 10g. Citizen of Whet Country? 14. Raca - American indian, Biack, White, etc. Specify: WHITE 16b. Kind of Business/Industry OWN HOME 18. Mother's Neme (First, Middle, Meiden Surname) ty or Town, Stete, Zip Code) T. SAVAGE, MD21545 Location - City or Town, Stete EYERSDALE, PA LE, MD 21502 Approximate intervai Batween Onsat end Death ioyean

ne State

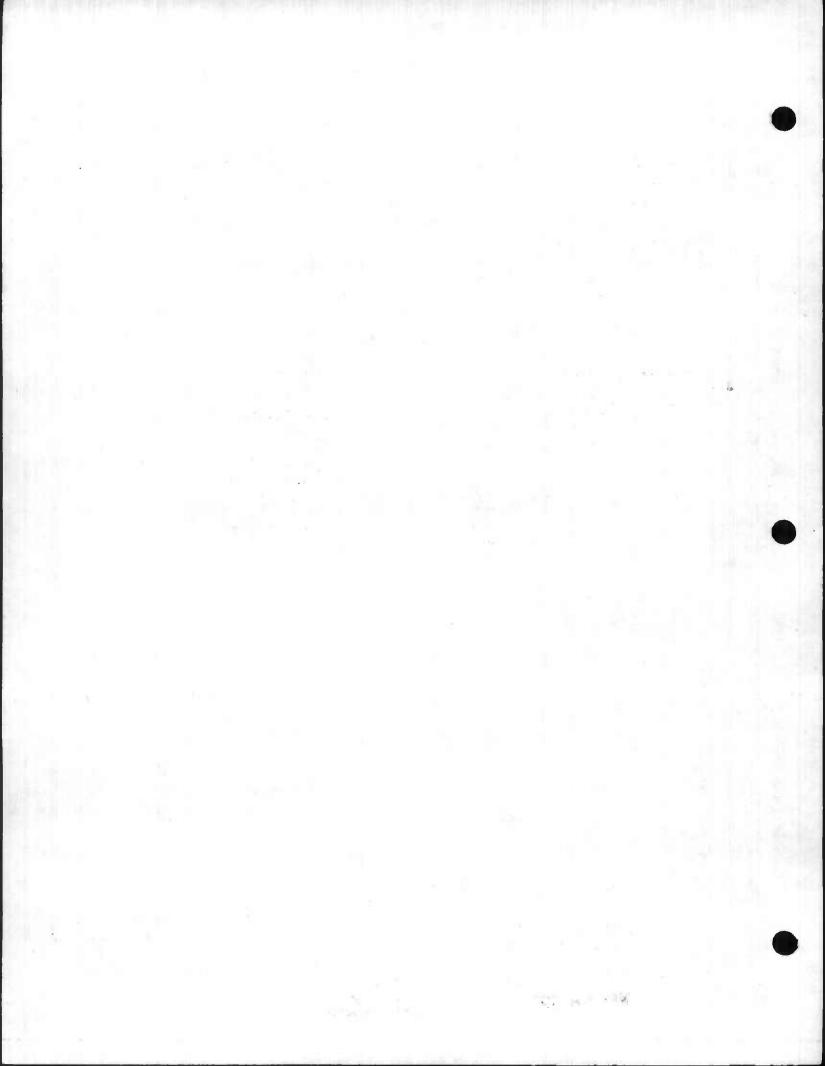
Registrar







Datail Litzabetii Green War 1/ 1000 10.2/ -		lent's Nama (Fir	st, Middla, La	st)		301		of Death		2. Data of De			3. Time	e of Death
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Section   Sect					ber)								1	
Total State   Total State	214-	-07-2220	) 1						24 Hrs. Min.	8. Deta of Bir Month De May 3,		9. Birth	nplace (Sta untry) and	ta or Foreign
100. Street and Number  15817 Rockville St.  11. Merell Status  11. Morell Status  12. Morell Status  12. Mo	10a. Stat	a 10b	County										10d. Inside	e City Limits
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The New Married   Content   Conten	100000		ille St	•							10g. Citiza USA	an of What Co	untry?	
College (Indo My highest griest completed)   College (Indo St)	101	lever Married		Armed Ford 1 Tes 2 If Yes, Give	es? No	li li		1		cify Yas or No Rican, etc.)		Black, White	atc.	( <sub>e</sub>
19a. Informant's Name/Relationship (Type, Print)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)   15817 Rockville St., Lonacoming, Md. 21539   20b. Nation of Disposition   20b. Nation of Nation   20b. Nation of Nation   20b. Nation   20	Eleme	(Specify or	fy highest gra	da completed) College (1-	4or 5+)	(Giva	kind of work d DO NOT use r	ccupation ona during mos stired)	st of workin	ng	16b. Kind		ndustry	
20a. Marbod of Disposition  3 Description of Description  4 Donation 5 Other (Specify)  21. Signature of Furarial Service Desirese  22. Signature of Furarial Service Desirese  22. Signature of Furarial Service Desirese  23. Eggl. Enter the disease, or complications that caused the death. Do not enter the mode of dyng, such as cardiac or respiratory errest;  22. Rept. Enter the disease, or complications that caused the death. Do not enter the mode of dyng, such as cardiac or respiratory errest;  23. Enter the disease, or complications that caused the death. Do not enter the mode of dyng, such as cardiac or respiratory errest;  23. Enter the disease, or complications that caused the death. Do not enter the mode of dyng, such as cardiac or respiratory errest;  24. Part Enter the disease, or complications that caused the death. Do not enter the mode of dyng, such as cardiac or respiratory errest;  24. Part Enter the disease, or complications that caused the death. Do not enter the mode of dyng, such as cardiac or respiratory errest;  25. Part Enter the disease, or complications that caused the death. Do not enter the mode of dyng, such as cardiac or respiratory errest;  25. Enter the disease, or complication or contributing to death but not resulting in the underlying cause given in Part I.  26. Due to (or as a consequence of):  27. Was cast entered to medical seasing in the underlying cause given in Part I.  28. Was cast entered to medical seasing in the underlying cause given in Part I.  28. Was cast entered to medical seasing in the underlying cause given in Part I.  28. Place of Death (Check only one)  29. Was cast entered to medical seasons in the cause of death of the completion of cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of the death of the cause of the cause of the cause of the cause of the cause of the cause of the cause of	17. Fathe Wesle	or's Nama (First,	Middle, Last)	0								umama)		
20. Method of Disposition  All Burlai 2 Clorametion 3 Removal from Stata  4 Donation 5 Clother (Specify)  21. Signature of Funnaria Services Logisee  22. Name and Addrass of Facility  Einhard managements of Funnaria Services Logisee  22. Name and Addrass of Facility  Einhard managements of Funnaria Services Logisee  22. Name and Addrass of Facility  Einhard managements of Funnaria Services Logisee  22. Name and Addrass of Facility  Einhard managements of Funnaria Services Logisee  23. Fart finary managements of Funnaria Services Logisee  24. Name and Addrass of Facility  Einhard managements of Funnaria Services Logisee  25. Name condition, security in death)  26. Dua to (or as a consequence of):  27. Dua to (or as a consequence of):  28. Dua to (or as a consequence of):  29. Dua to (or as a consequence of):  29. Was an autopsy  24. Was an autopsy  25. Was case (referred to medical  28. Place of Death  1   Yes   2   No  29. Name of Ones I and Number or Rural Route Number,  29. Countier							-							
23. Signature of Parties   1. Service   1.				usband	20b. F	Place of Dispos	sition (Name o	M .	.,Lor	naconii	ng,Md	• 21539	Fown Stets	
23. Spart. Enter the disease or combostions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errast.  Lonaconing, Md. 21539  23a. Fart. Enter that disease, or combostions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errast.  Immediate Cause (Final disease or condition, resulting in death)  Due to (or as a consequence of):  Sequentially list conditions.  Sequentially list conditions.  I any, leading to immediate Cause (Pinal disease or condition).  Due to (or as a consequence of):  Cause (Disease or injury that ministed events or line).  Due to (or as a consequence of):  Cause (Disease or injury that ministed events or line).  Due to (or as a consequence of):  Cause (Disease or injury that ministed events or line).  Due to (or as a consequence of):  Cause (Disease or injury that ministed events or line).  Conditions or line that ministed events or line th	12	Burial 2 Cre	metion 3 🗆		lata Lau	rel Hil	1 Ceme	tery	Ma	ay 18,	Mosco	w Mills	,Md.	
Immediate Causa (Final disease or condition neutling in death)	PC	2 6	m. P.	-		Eic	chhorn-	McKenzi	e Fur	neral H	Home			
Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other algnificant conditions contributes to the cause of death	diseasa resulting	or condition		a	Dua to (d	or as a conseq		4mc A				1		
1   Yes   2000   3   Probably   4   Unknown   24a. Was an autopsy performed?   24b. Wara autopsy findings available prior to completion of cause of death?   1   Yes   2   No   1   Yes   20   No	Cause (E that initia	intar Underlying Disease or injury Ited events	ns, ata	С.	Dua to (d	or as a conseq						1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
1   Yes   20 No   3   Probably   4   Unknown   24a. Was an autopsy performed?   24b. Wara autopsy findings available prior to completion of cause of death?   1   Yes   2   No   1   Y				d										
25. Was casa rafarred to medical axaminar?    1	Part II. Ot	1		entributing to dea	th but not ras	ulting in tha ur	nderlying caus	a given in Part I						
25. Was casa rafarred to medical axaminar?    To year   Hospital:   Impatient   2   ER/Outpatient   3   DOA   Other:   A   Nursing Homa   5   Residence   6   Other (Specify)		CONG	CTIV	E MENT	NT P	HLUR	E	-11				8	vailable pr	ior to
Asaminar?    Yas   2  No										10	Yes 2	No 1	☐ Yas	2 No
Naturel   Accident   S   Pending invastigation   S   Pending invastigation   S   Suicide   A   Homicide   Sea. Place of Injury - At homa, farm, street, factory, office   Sea. Place of Inju	axam	inar?	medical	Hospital:	patient 2	ER/Outpatien	t 3 DOA	Other				□Other (Spec	cify)	
4 Homicide  29a. Certiflier (Check only one)  29b. Signatura and title of certifler 29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number	1 20	aturel 5 [	invastigation	28a. Date of (Month)	Injury	28b. Tima of Injury				8d. Describe	how injury	occurred		
(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.  29b. Signature and title of order.  29c. License number  29d. Date signed (Month, Day, Year)			determined	28a. Ptace of building	f Injury - At h	oma, farm, stre	eet, factory, of	fice	2	81. Location ( City or To	Street and wn, Stata)	Number or Ru	ral Route f	lumber,
	(Che	ck only 2	Certifying Phy Redical Exam	iner: On the bas	is of examina	wiedge, death tion and/or inv	occurred at the restigation, in	na tima, data an my opinion, daa	nd place, a oth occurre	nd dua to the id at tha time,	causa(s) a data and p	nd mannar as placa, and dua	stated. to the caus	se(s)
D33417 MAY 15, 1999	29b. Sign	atura and title	Contiller									-		(r)
		(1)	1111				1 7)	17417			4444	15 19	99	



Physician/Medical ğ Completed

Be 27. Manner of Death

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. SEIZURE DISORDER 25. Was case referred to medical examiner?

ä Ahar

Certification: To

within 24 hours a To the Funeral I 3

> State Registrar

Medical

CARON LOCKE

31. Dete filed (Month, Day, Year)

1€ Yes 2□ No

1 CNatural

2 Accident

3 Suicide

29a. Certifier (Check only one)

296. Signature

4 Homicide

28a. Dete of Injury (Month, Day Year)

5 Pending investigation 5 ☐ Could not be

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of Injury

1 Yes 2 No 28f. Location (Street and Number or Rurel Route Number, City or Town, State)

28c. Injury at Work?

OCME

MAY 15, 1999

28d. Describe how injury occurred

24a. Wes an autopsy performed?

100:

3. Time of Death

23:45 PM

10d. Inside City Limits

Approximate Intervel Between Onset and Death

24b. Were autopsy findings aveilable prior to completion of causa of deeth?

2 No

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

1 Xes 2 No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Data signed (Month, Day, Year)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Deeth (Check only one)

address of person who completed ceuse of death (Item 23a) (Type, Print)

Hospitel:

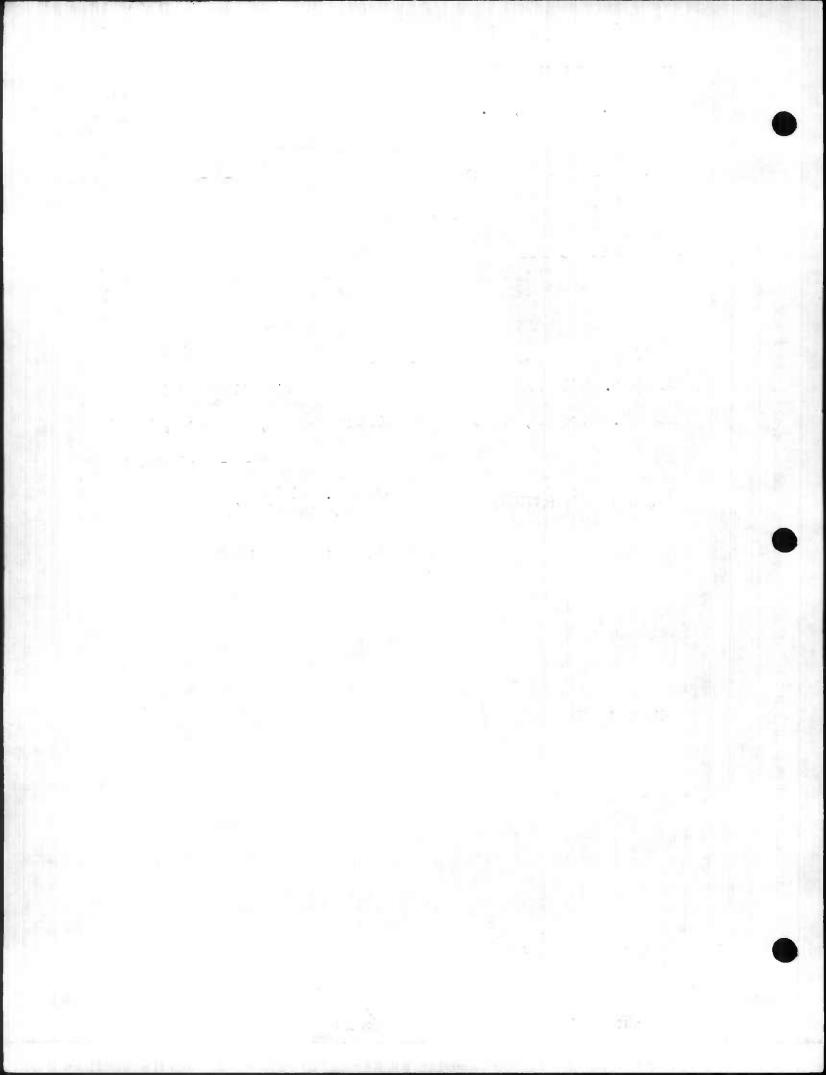
111 Penn Street, Baltimore, Maryland 21201 32. Registrer's Signeture

**DHMH 16 Rev 6/95** 

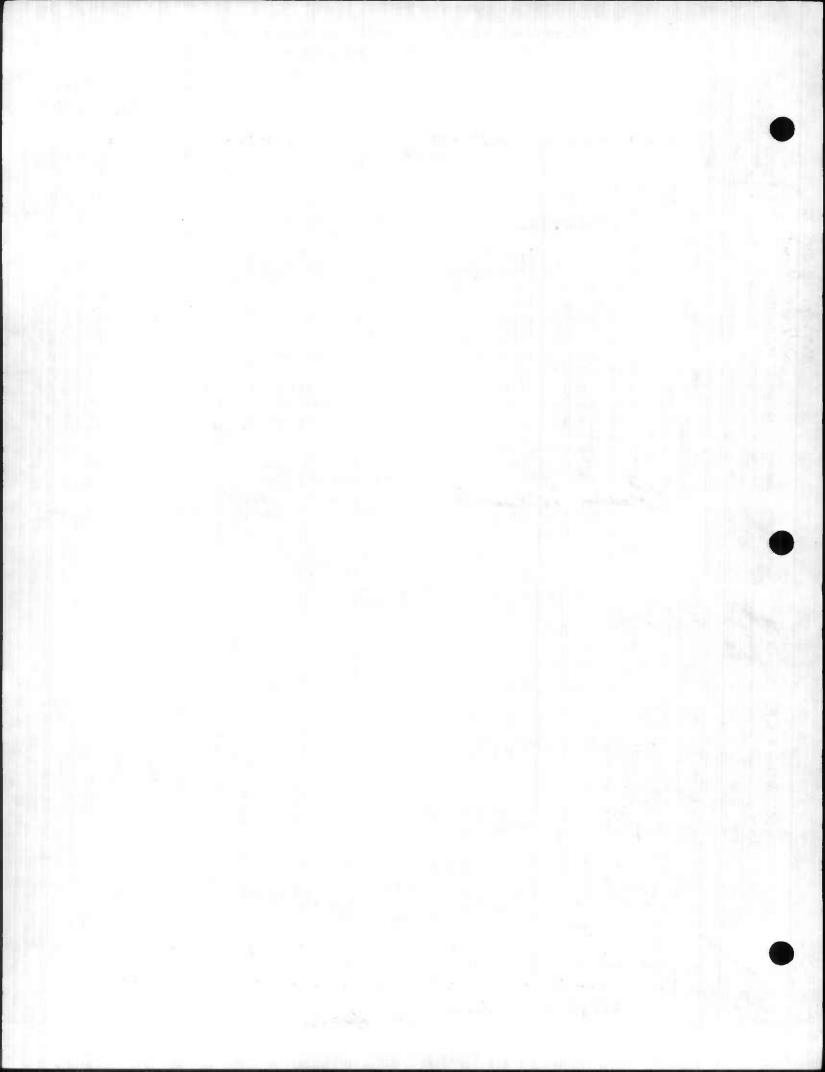
Hospital or Attending deeth.

å

after death



		State of Maryland	Certificate o			Reg. No.		7225
Physician	Decedent's Nama (First, Middla, Last)     NIET CONT				2. Data of Dea	Day	Yaer	3. Tima of Death
/Medical	NELSON 4a Facility Nama (If not institution, giva s	GATTIS street and number)		4b. City, Town, or L	ocation of Death	10	of Death	2000
Examiner	PENINSULA REGIONA		TER	SALISE	URY		OMICO	
Funeral	5. Social Sacurity Numbar 6. Sax		est birthday) If Undar 1 Ya. Months Day		8. Data of Birt (Month, Da	h V Year)	9. Birthpla	ca (Stata or Foraigi
Director	217-28-4564	<sup>M 2□ F</sup> 66	Yrs.	Tions Will.	10/17		Md	
w.	Usual Rasidence of Dacedant  10a. Stata 10b. County	10c. City.	Town or Location				100	d. Insida City Limits
4 sho	Md Wicomi							Yas 2□No
in the Mar or 284-18 by coults	Md Wicomi	co pua	intico	1		10g. Citizen of V	What Countr	y?
ath with the Marylan 23e or 28e-f show xet to resilt at rai Director	P.O. Box 1	71	2185	56		U.S.A		
r items 23 incer must Funeral		12. Was Decedant Evar in U,S Armed Forcas?	. 13. Was Decedant of	of Hispanic Origin? (Spuban, Maxicen, Puarto	pecify Yas or No-	14. Rac	e - Amarice	
by	1 ☐ Navar Married 2 ☐ Married 3 ☐ Widowed 420 Divorced	1 X Yas 2 □ NoWW 2 If Yas, Giva Yaar or Datas:	1 Yas 230 N		nican, acc.)	1000	Bla	
ed within 72 hours ygiene. or than "natural", rt, the Medical Exit, the Medical Exit.	15. Decedant's Educ (Specify only highast grade	cation a completed)	16a. Decedent's Usual Occ	cupation	cina	16b. Kind of Bu	usinass/Indu	stry
within than than omple	Elamantary/Secondary (0-12)	Collaga (1-4or 5+)	(Giva kind of work doi lifa. DO NOT usa rat			Oyste	rman	
	17. Fathar's Nama (First, Middla, Last)	0	Farmer & W	aterman 18. Mothar's Nam	o /First Middle	Maiden Cumen	201	
Saby W							/d.)	
d 2 should be the end Mente of the marked treumatic e	Norman Gattis  19a. Informant's Name/Ralationship (Ty)	ne Printl	19b. Mailing Addrass (Stre	Eliza E			Stata Zin (	Code)
d 2 s	Ruth Mae Collin							
Pages 1 and inent of Health int: If Item 27 lary or other tr	20a. Mathod of Disposition  ★□ Burial 2 □ Cramation 3 □ R	20b. Pla cer	434 Hampto aca of Disposition (Nama of matary, cramatory or other p	placa)	Data	20c. Location -	City or Tow	m, Stata
교원들 등	4 □ Donation 5 □ Othar (Specify)  21. Signature of Funaral Sarvice License	V . A		trass of Facility	/17	Hurloc	k, M	đ
Depe Impo eny le	Youreline W	M00-417	Messick Bivalv	Funeral e, Maryl	Home, and 21	P.O. 814	Box	61
	23a. Pert1. Enter the diseese, or complishock, or haart failura. List only or	cutions that caused the deeth.	Do not enter the mode of o	tying, such es cardiac	or raspiratory as	rast,	1 1	Approximata Intarval Batween
Physician /Medical Examiner	Immediate Cause (Final disass or condition rasulting in death)	Dua to (or	as a consequence of):				1	Onsat and Death
executed in end iel-transit Examiner		long	bour				1	mi
icate be executed physician end s the buriel-transit	Sequantially list conditions, if any, leading to Immadiata causa. Enter Underlying	Due to (or	as a consaquanca of):				1	
physicia the bur	Causa (Disaasa or Injury that initiated avants rasulting in death) Last	Dua to (or a	as a consequance of):				1	
	lasuring in daalify East	1						
death c e attend ad for us		**						
d by the letache	Part II. Other significant conditions con	atributing to death but not result	ting In tha undarlying ceuse	givan In Part I.		tobacco usa co Yee 2□ No	ntribute to	the cause of death' ably 4 Dunknow
requires that seen signed i hould be det	010	2			24e. Wes	en eutopsy		e eutopsy findings
ple ple	alcohol oli	re-			perfo	rmed?	com	labla prior to apletion of cause eath?
icate harry page					10	Yas 200 No	10	Yas 2□No
Physicien: The this certificate ral director, page Co	25. Was casa rafarred to medical axaminar?	lospital:		26. Placa of Dea Other:				
5 5 7	1 ☐ Yas 28€ No 27. Mannar of Death	1. Inpatiant 2LLE	Proutpetient 3LI DOA	4 Li Nursing n	oma 5 ☐ Rasid	dence 6 ⊟Oth now injury occur		
Attending 6 or death.  Sector: After by the funer iffication.	1 ☐Natural 5 ☐ Pending 2 ☐ Accidant Investigation	(Month, Day Year)		njury at Vork? □ Yas 2 □ No				
To the Hospital or Attending P within 24 hours after death.  To the Funeral Director: After completely filled in by the funeral Medical Certification:	3 Suicida 6 Could not be dataminad	28a. Place of Injury - At horn building, atc. (Spacify)	ma, farm, straat, factory, office	08	28f. Location ( City or Tox	Street and Numb vn, State)	per or Rural	Routa Number,
n 24 hours n 24 hours ne Funer pletely fill edical	29a. Cartifiar 1 Certifying Phys (Check only one) 2 Medical Examir	ician: To the best of my knowner: On the basis of axamination and manner steted.	ladga, daath occurred at the on and/or invastigetion, in m	time, date and placa y opinion, daath occur	, and dua to tha rred at the time,	causa(s) and made and placa,	annar as sta and due to	ited. tha ceuse(s)
within To the comp	29b. Signatura and titla of certifiar	100	29c. Lica	ansa nu <i>m</i> ber		29d. Data signe	d (Month, D	ay, Year)
W. W.	1/1/X	11/1	12	29349	?	5/101	199	
2/0	30. Name and addrass of person who co	impleted causa of death (Itam :	23a) (Type, Print)	1-1-		///	1-	
3 18	Dr. William Role	oins, 1104 t	leathway 1	Drive Sa	Disbur.	, md. 2	1801	
State Registrar	31. Data filad (Month, Day, Year)	32. Ragistrar's Signatu	ura 6	,	,			



#### Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth Month JOHNNIE MAE GOODMAN nous 1995 4b. City, Town, or Location of Death 4c. County of Deeth WICOMICO SALISBURY if Under 1 Yeer | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year)

3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 0/35 /Medical 4a Fecility Name (If not institution, give street end number) Examiner PENINSULA REGIONAL MEDICAL CENTER 5. Social Security Number Birthpiece (State or Foreign Country) **Funeral** Deys Hours 1 M 2 X F 000 Yrs. Director 219-60-0310 JULY 8, 1947 FLORIDA Usuel Residence of Decedent the Maryland 10e Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examiner, must be notified as MD. WICOMICO FRUITLAND 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 305 ELIZABETH AVE. 21826 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 Ø No If Yes, Give Year or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian. 11. Maritel Status Black, White, etc. 1 Never Married, 2 Married 1 ☐ Yes 2 No py ohnnie goddman 3 Widowed 4 Divorced AFRO-AMERICAN 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Eiementery/Secondary (0-12) Coilege (1-4or 5+) 9th DOMESTIC HOMEMAKER 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) and Mental ROBERT OSBORNE MABL E ? 2 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Peges 1 and 2 MARY OSBORNE 305 ELIZABETH AVE., FRUITLAND, MD. 21826 Depertment of Health Important: if item 27 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Buriel 2 Cremetion 3 Removel from State ST. JAMES UM CH. CEM. 4 ☐ Donetion 5 ☐ Other (Specify) 5-18 WESTOVER. MD. 21. Signature of Funerai Service License 22. Neme and Address of Facility JOLLEY MEMORIAL CHAPEL 1213 JERSEY ROAD; SALISBURY, MD. 21801 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** Immediete Ceuse (Finei diseese or condition resulting in deeth) /Medical **Examiner** Examiner certificata be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) and ettending physician for use as the burial Physician/Medicai Due to (or es e consequence of) The law requires that the death signed by the e 23b. Did tobacco use contribute to the cause of death? P.O. Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert II. 1/2-Yes 2□ No 3 Probably 4 Unknown by 24e. Wes en eutopsy performed? Completed Deed page 2 has 1 Yes 2 No cartificata 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one)

Division of Vital Records, Physician: 101 1 ☐ Yes 1 Hatient 2 ER/Outpetient 3 DOA After this funeral 27. Menner of Deeth Certification: 28b. Time of 28c. Injury et Work? or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No deeth 2 Accident within 24 hours after deet To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide

24b. Were autopsy findings avelleble prior to completion of cause of deeth?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

29a. Certifier propertifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and menner as stated a Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the (Check only miner: On the besis if examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end pleca, end due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

o completed cause of deeth (Item 23e) (Type, Print)

1999

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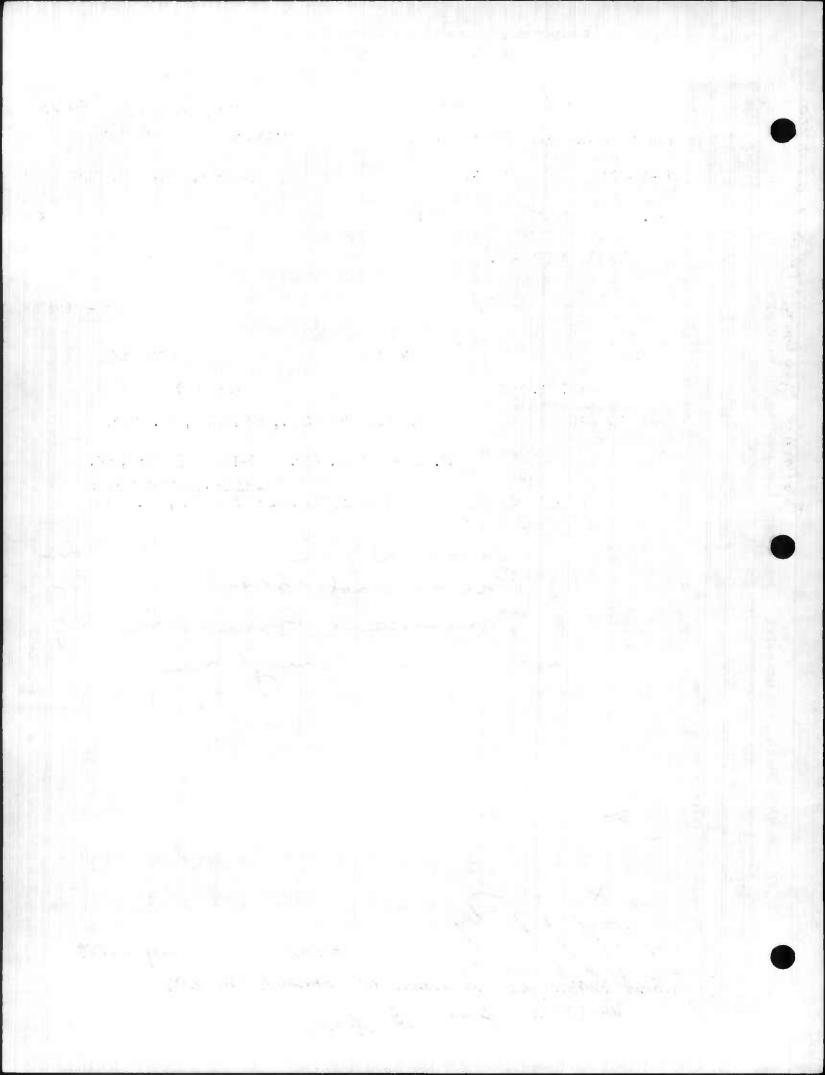
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State Registrar

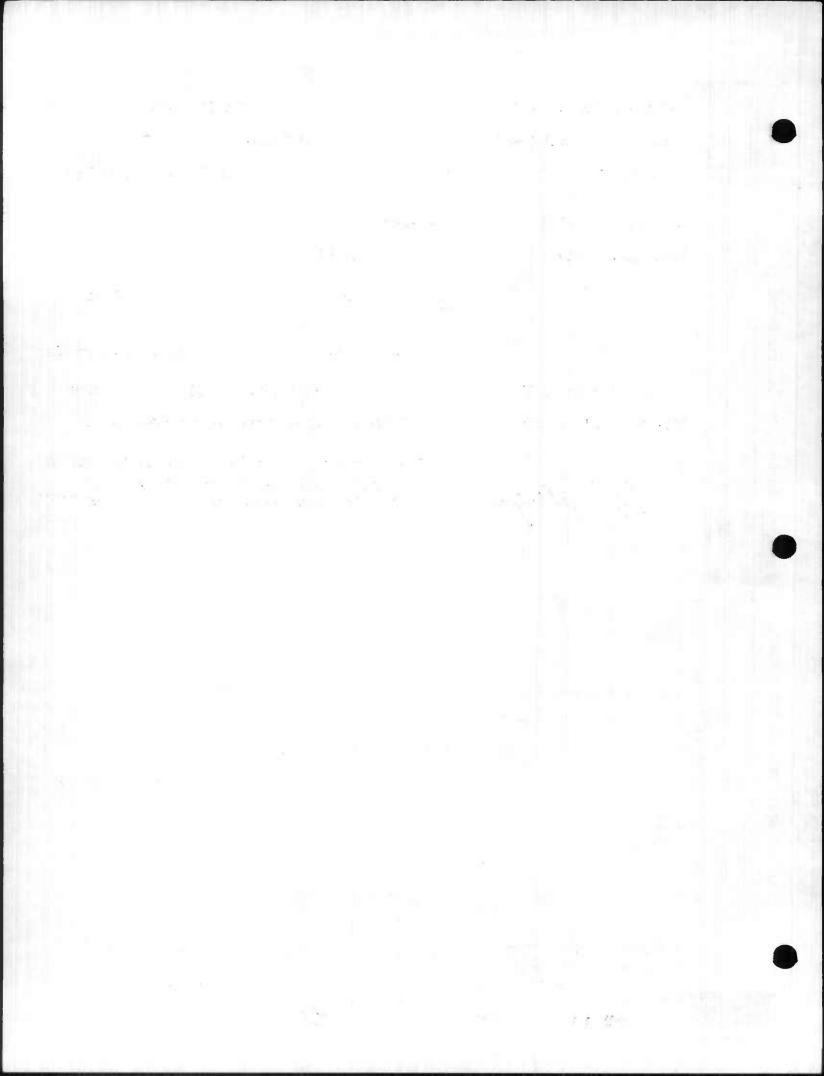
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29b. Signature and title

32. Registrer's Signeture



		State of Maryla		tificate of		i wentai n	Reg. No.		1227
Physician /Medical	Decedent's Name (First, Middle, Last, Charles Vernon	Gill, Sr.				2. Date of D Month May 11	Day	Year	3. Time of Death  2 2 = 1 (
Examiner	4e Facility Neme (If not Institution, give					or Location of Dea			
Funeral	Fallston General  5. Social Security Number 6. Se	-	s. last birthday)	If Under 1 Year	Fallst	rs. 8. Date of B	100	erford 9. Birthple	ace (State or Foreign ry)
Director	216-20-6687	™ 2□ F 72	Yrs.	Months Deys	Hours M	Apr. 1	.9, 1927	Mary	land
and w	Usual Residence of Decedent  10a. State 10b. County	10c. 0	City, Town or Lo	cation				10	d. Inside City Limits
Maryli ta-f aho tifled a	Maryland Harford	đ	Edgewoo	od					1 ☐ Yes 2 No
ith the Mail or 28s-4 s	10e. Street and Number		_	10f. Zlp Code			10g. Citizan of \		ry?
a 23a	1932 Steven Drive	12. Was Decedent Ever in	116 12 1	21040		(Specify Yes or N	lo. 14 Bac	USA e - America	n Indian
020  wrs after death with the Marylan  at', or items 23s or 28s-f show  Exercited must be notified at  by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	Armed Forces?  1 Tyes 2 No If Yes, Give Year or Dates: WWI		Yes, specify Cub	Specity:	erto Rican, etc.)	Blad	k, White, e	tc.
Nore, Maryland 21215-0020  ges 1 and 2 should be filed within 72 hours after death with the Maryland to fleelih and Mertal Hygiene. If flam 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Eventuar man be notified at To Be Completed by Funeral Director	15. Decedent'a Edu (Specify only highest grad	cetion	16a. Deced (Give life. L	ent's Usual Occup kind of work done DO NOT use retire	pation during most of v d)	vorking	16b. Kind of B		acturing
Hygie Hygie of the Co	17. Father's Neme (First, Middle, Last)		Sicce.	L WOLKEL	18. Mother's N	lame (First, Middl			ccuring
Maryland d 2 should be file th and Mental Hy 7 is marked othe traumatic event		ill			Wilhemi	1,500	~		erman
Maryle 42 should 42 should hand Mer 7 is marke fraumatic To	19a. Informant'a Name/Relationship (T)			-		Rural Routa Num			
re, n 1 and Heelth am 27 other tr	Amelia L. Gill / W. 20a. Method of Disposition		Place of Dispo	sition (Name of		lgewood,	20c. Location		
Pages nent of l nrt: If he	1 ☑ Burlal 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)			Cemeter		5-15-99	Paltim	oro M	Maryland
Baltimore, Ma permit. Pages 1 and 2.s Department of Heelth at Important: If Item 27 is any Injury or other trau	21. Signeture of Funerel Service Licens  23a. Part V Enter the disease, or complishock, or heart fallure. List only or	Lucki	1:	317 Cokes	McComas sbury Ro	s III Fur bad, Abir	ngdon, M	rylar	nd 21009 Approximete
Physician /Medical Examiner	Immediata Causa (Final disease or condition resulting in death)	ASUV D	(or as a consaq	uenca of):					Onset and Death
The cords, P.O. Box 68/60,  The law requires that the death certificate be executed ste has been signed by the attending physician and page 2 should be detached for use as the bunial-transit completed by Physician/Medical Examiner.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disass or injury that initiated avents	9	(or as e conseq						
P.O. BOX 68/ lat the death certificate d by the attending phy latached for use as the Physician/Medit	rasulting in death) Last	1	(or as a conseq	uence otj:					
death death death at a the at for sicla	Part It. Other significant conditions cor	ntributing to death but not re	asulting in the u	ndarlylng ceuse gi	ven in Part I.	23b. Di	d tobacco use co	ntribute to	the cause of death?
dS, P.O. BOX 6 ires that the death certific signed by the attending of d be datached for use as d by Physician/Me		CHF				10	Yes 2□ No	3 Prob	ably 4 Unknow
The law requires th The law requires th seta has been signer page 2 should be d Completed by		DIABETES	MELL	ITUS TY	PE I		s an autopsy formed?	con	re autopsy findings ilable prior to apletion of cause leath?
Tha in the page page						1□	Yes 2 No	1 🗆	Yes 20 No
Yoldan: The law is cartificete has be director, page 2 s	25. Was case referred to medicel examinar?					Death (Check only	one)		
- S 0 0 L	THES ZLINO		ER/Outpatien	1 3LI DUA		Home 5 Re			)
Division or to the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 1	27. Menner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At			ry at rk?  Yes 2 □ No		s how Injury occur (Street and Num)		Routa Number,
Vital or / vital or /	4 Homlcida datarmined	building, etc. (Spec	cify)			City or T	own, Stata)		
ne Hospi n 24 hou he Funer pletely fill edical		sician: To the best of my ki ner: On the basis of exami and manner atated.							
To the To the comp	29b. Signature and title of certifiar			29c. Licens	se number		29d. Date signe	d (Month, E	Day, Year)
mel	Mammy	~	DME	00	ME		MAYII	1999	
VA4	30. Nama and address of person who co	empleted cause of death (It		Print)	40 210	014 4	10-879	-656	4
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	1					



# Please Type or Print In Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Day Yee **Physician** GOLDIE MARY April 30, 1999 11:15 P.M /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Harford Fallston General Hospital Fallston If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Deys 1□M 2⊠F Months Yrs. N. Carolina 215-30-1172 89 Aug. 21, 1909 **Director** Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f ebov traumstic event, the Medical Experience must be notified at 1 Yes 25 No Maryland Harford Abingdon Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21009 USA 19 Haven Avenue Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 220 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2X No Specify: p 3€ Widowed 4 Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Holds, Goldie 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Tailor Retail Clothing Store 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Pages 1 and 2 should be facent of Health and Mental Int. If Item 27 Is marked of DeBoard Lambert Charles Parker Laura Jane 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 19 Haven Avenue, Abingdon, Maryland Cecil L. Goins - Son Item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete HXBurial 2 ☐ Cremation 3 ☐ Removal from State = 8 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Grdns. 5/4/99 Bel Air, Maryland 21. Signature of Eugeral Service Licenses 22. Name end Address of Facility Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 23a. Part 1. Enter the disease, or complications the required the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or hum failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final ro vasen la disease or condition resulting in deeth) Examiner Examiner osclerone physician and the burial-transit that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Due 16 (or es e consequence of): tersion P.O. Box 68760, Physician/Medicai Due to (or es a consequence of): attending p as signed by the a 23b. Did tobacco use contribute to the cause of death? Part If. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Division of Vital Records, p 24b. Were autopsy tindings available prior to completion of cause of deeth? Completed 24e. Was en eutopsy performed? is certificate has director, page 2 2 No 1 ☐ Yes 2 ☐ No Attending Physician: Be 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 12 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of fnjury (Month, Day Year) 27. Mannes of Death 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of Natural 5 Pending death. 1 Yes 2 No 2 Accident investigation aftar deat 6 Could not be determined 3 Sulcide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide n 24 hou. he Funeral Directilled in 8 29a. Certifier 🖾 Cartifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated. To the Hosp within 24 hor To the Fune complately fi Medical (Check only one) 2 Madrcal Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end manner stated. 29b, Signature god title 29c. License number Pate signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) n ETER 1308 Business( 31. Date filed (Month, Day, Year) 32. Registrer's Signature State Registrar 3

Lambert Charles Parker

Laura vane

NEDOGER

Cecil L. Goins - Son

19 Haven Avenue, Abingdon, Maryland 21009

XX

Rel Air Memorial Grdns. 5/4/99 Bel Air, Maryland

Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009

- 22

BUILT BUILDING

State of Maryland / Department of Health and Mental Hygiene

7,7	1. Decedent's Name (First, Mid	idle, Last)		Certifica		Jau	2. Date of Dea		Year	3. Time of Death	
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niner	4a Facility Name (If not institut	ion, give street and num	ber)			4b. City, Town, or	Location of Death				
	6006 Edward D	rive				Clinton		Princ	e Geor	rges	
1	5. Social Security Number		. Age (In yrs. last i	oirthday) If Unc	er 1 Year S Days	If Undar 24 Hr				ce (Stata or Foreign	
17	577-48-3746 Usual Residence of Decedent	1□M 2XF	63	Yrs.	Duys	110013	NOV 25	, 1935	Washir	ngton,D.C.	
/7	10a. Stata 10b. Coun	ty	10c. City, To	wn or Location					100	d. Inside City Limits	
Director			WASHI	NGTON, 1	).C.					1⊠Yes 2□No	
Dire	10e. Street and Number			10f. 2	ip Coda			10g. Citizen of V	Vhat Country	y?	
Funeral	2433 Shannon					020		United			
2	11. Marital Status  1 Never Married 2 Marital 3 Widowed 4 Divorce	Armed Ford	2 X No			dispanic Origin? ( an, Mexican, Pue Specify:	Specify Yas or No- rto Rican, atc.)	Blac	e - Amaricar ck, White, etc : Black	c.	
ered	15. Decede	ent's Education lest grade completed)	16	a. Decedent's Us	uel Occup	oation during most of w d)	orking	16b. Kind of Bu	siness/Indu	stry	
Completed	Elementery/Secondery (0-12	1	40f 5+)			d)		D	G 1	1	
3	10 17. Father's Name (First, Middl	e. Last)	H	ousekeej	per	18. Mother's No	ame (First, Middle,	Private Maiden Suman		DT	
Be C	James Belt	,					e Thomps		,		
0	19a. Informent's Neme/Relation	nship (Type, Print)	1:	9b. Mailing Addre	ss (Street		Rurel Route Numbe		State, Zip C	Code)	
	Sabrina Monroe						inton, M				
	20a. Method of Disposition		20b. Placa	of Disposition (A	ame of		Date	20c. Location -			
	1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		tate	Olivet C			5/11/99	Washin	eton	D.C.	
1	21. Signature of Funeral Service					ess of Facility	-,,		000119	2.0.	
Examiner	23a. Part1. Enter the disease, shock, or heart tailure. Li tmmediate Cause (Final disease or condition resulting in death)		RciNo		· Th			SE DC		Approximate interval Between Onset and Death	
ledical	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	c		a consequence o							
Physician/N	Part II. Other significant condi	tions contributing to dea	ath but not resulting	in the underlying	g cause gi	ven in Part I.	23b. Did	obacco use co	ntributa to t	the cause of death?	
y Phy							100	Yes 2□No	3 ☐ Probe	ably 4 Unknown	
Completed by								an autopsy rmed?	com	e autopsy tindings lable prior to pletion ot causa eath?	
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e C	25. Wes case reterred to medic examiner?				-		eath (Check only o	nne)		Dayakters	
10	1 ☐ Yes 2 No 27. Manner of Death			Outpatient 3	DOA		Home 5 Resid		ner (Specify)	Residence	
Heamon	1 Netural 5 Pend 2 Accident invest 3 Suicide 6 Coul	stigation d not be	ot Injury - At home,	Time of Injury M		ny at irk? ]Yes 2 □ No	28t. Location (	now Injury occur		Route Number,	
Certification:	4 Homicide		g, etc. (Specify)				City or To	vn, State)			
edicai	29a. Certifier Certify (Check only one) Medica	ring Physician: To the base Examiner: On the base and manner	sis of examination	ge, death occurre and/or invastigati	ed at the ti on, in my	me, date and pie opinion, death oc	ce, end due to the curred at the tima,	cause(s) end mo data and place,	enner as sta and dua to t	ited. the cause(s)	
Me	29b. Signature and title of certification	lier			9c. Licen	sa number		29d. Data signe	d (Month, D	Pay, Year)	
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State of Maryland / Department of Health and Mental Hygiene

					Certifica	ate of	Death		Reg. No.	-4	1230
		1. Decedent's Neme (First, Middle, L	est)		-91		2111	2. Date of De	eth Day	Year	3. Time of Death
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Funeral		5. Social Security Number 6.	Sex 7. Age (I	In yrs. lest bir	thday) If Und	der 1 Yeer					piece (State or Foreign ntry)
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Man	tor	Maryland Prince	George's	Boy	rie						1 X Yes 2 □ No
28 Port	Director	10e. Street and Number	000280			Zip Code			10g. Citizen of V	Vhet Cou	ntry?
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72 hours after death with the Maryland nature!', or items 23a or 28s-f show 3cel Examiner must be normed at	by Fur	1 Never Merried 2 Married 3 M Widowed 4 Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Yeer or Dates:				Specify:	erto Rican, etc.)	Specify	k, White,  Wh	ite
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2 sh and is m		19e. Informent's Neme/Reletionship						Rural Route Numb			
		Susie Harrigan -						Bowie, 1			721
5 5 5 5		20e. Method of Disposition  1 □ Burial 2 🕅 Cremetion 3    4 □ Donetion 5 □ Other (Spec	Themone mour grare		Disposition (f ry, crematory of Lean Cr			05/15/99	20c. Location -		
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4		23a. Pert1. Enter the disease, or cor shock, or heert fature. List on	one ceuse on each line.	0 000000	iot otitor tito ii						Interval Between Onset and Deeth
Physician /Medical		Immediate Cause (Final		4 /	_		,				2 1
Examiner		diseese or condition resulting in deeth)	0. 1-11		57	50	05/1				South.
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ath certification attending for use as	Š		d								
requires that the death certificate be executed requires that the death certificate be executed seen signed by the attending physician and thould be detached for use as the bunal-transit	Physician/	D + 11 O 11 + 12 + 12 + 12 + 12 + 12 + 12						OOL DIE			
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v require been si should l	ete							part	ormed?	C	vailable prior to empletion of cause
e law has b	Completed								-		death?
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Physician: The this certificate ral director, par	Be	25. Was case referred to medical exeminer?	Hospitel:			10	26. Plece of D	Death (Check only	one)		
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or Attending after death. Director: After d in by the fune	Ē	4 Homicide determine	28e. Place of Injury building, etc. (	- At home, te Specify)	rm, street, fec	tory, offica			wn, State)	er or Hur	el Route Number,
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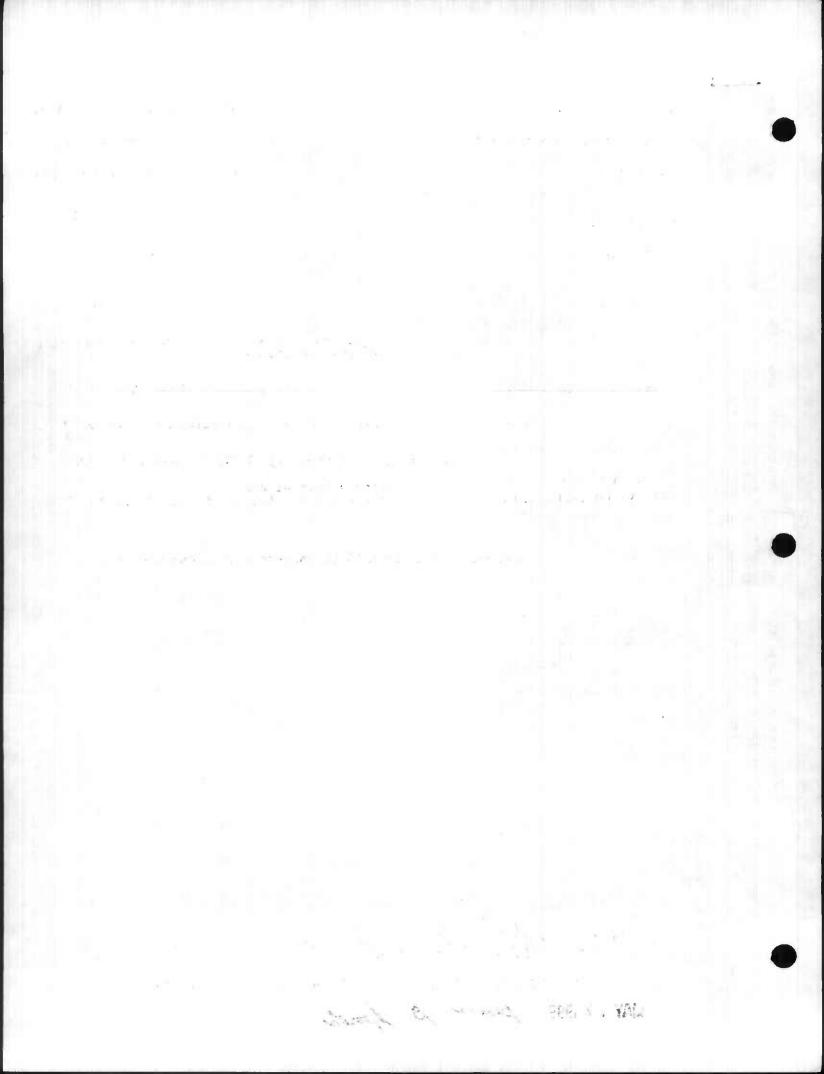
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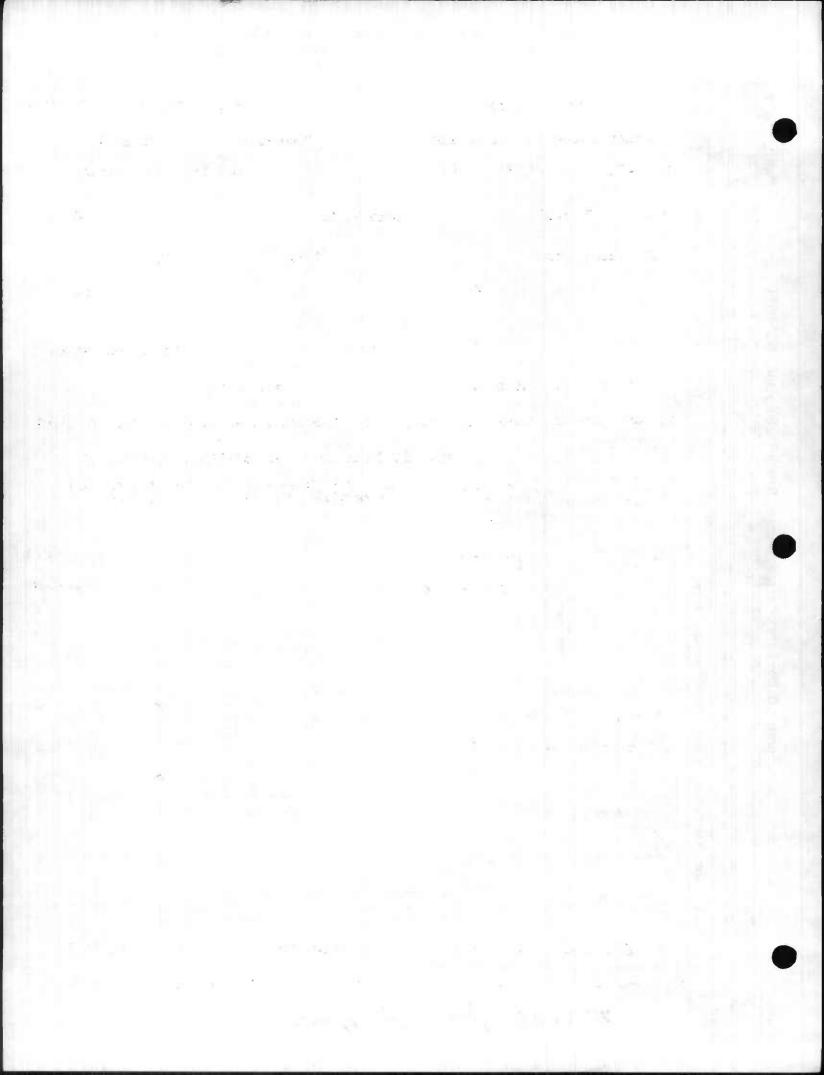


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 12:29 PM Martha Harrison 13, May 1999 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street and number) Examiner Fairhaven Life Care Community Sykesville Carroll 8. Dete of Birth (Month, Day, Year) May 13, 1915 9. Birthplece (State or Foreign Country) 5 Social Security Number 7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** Deys Hours 1 M 2 XF Months Min 84 218-10-7216 Yrs. Maryland Director Usual Residence of Decedant death with the Maryland 10d. inside City Limits 10a State 10h County 10c. City, Town or Location item 27 is marked other than "naturel", or items 23a or 28a-f show other traumstic event, the Medical Examinat must be notified at MD Carroll Sykesville 1X Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 7200 Third Avenue U.S.A.

14. Rece - American Indian,
Black, Whita, etc. 21784 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marltel Stetus pernit. Peges 1 and 2 should be filed within 72 hours efter or Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "naturel", or item 1 Never Merried 2 Married 1 Yes 2 No Specify: altimore, Maryland 21215-0020 White Specify: by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Department Store 18. Mother's Nama (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) William C. Harrison Mary Clough 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. informant's Neme/Ralationship (Type, Print) Mr. Robb Ross Hendrickson (attorney) 309 Cathedral St. Suite 200, Balt., MD 21201 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cramatory or other place) Dete 20c. Location - City or Town, Steta 1 ☐ Burial 2X Cremation 3 ☐ Removel from Stete 4 ☐ Donetlon 5 ☐ Other (Specify) 8 Carroll Cremation Serv. 5/15/99 Hampstead, MD Injury 21. Signeture of Funeral Service Licensee 22 Name and Address of Fecility HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) eny le Sykesville, MD 21784 (410)-795-1400 ian o 23e. Pert1. Enter the disease, or complications that claused the death. Do not enter the moda of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause of each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Causa (Final pneumania /Medical one week disease or condition resulting in deeth) **Examiner** Due to (or as a consequance of): Examiner 5 years advanced dementia siclan and burial-transit that the death certificate be executed Sequentielly list conditions, if eny, leeding to Immediate cause. Entar Underlying Ceuse (Disease or injury that initiated evants resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the Due to (or es e consequence of): 88 esn 23b. Did tobacco use contribute to the cause of death? Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yes 2 No 3 Probably 4 Unknown dehydration þ 24b. Wera autopsy findings aveilable prior to completion of cause of daath? 24e. Wes en eutopsy Completed diabetes mellitus page 2 1 Yes 2 No 1 □ Yes 2 □ No certificate or Attending Physician: director, 25. Wes case refarred to medical Be 26. Placa of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 10 1 Yes 2 No this 28a, Date of Injury (Month, Day Year) funeral 27, Mannar of Death 28b. Tima of 28d. Describe how injury occurred 28c. Injury et Work? Certification: After 1 Natural 5 Pending 24 hours efter death. 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Hospital (Ertifying Physician: To the bast of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Cartifian Medical completely (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number em C. m MD D34406 May 13, 1999 30. Nama end addrass of person who complated causa of daath (Itam 23a) (Type, Print) Richmond P. Allam, 1645 Liberty Rd., Eldersburg, MD 21784 31. Data filed (Month, Day, Year) 32. Registrar's Signeture State Deneva MAY 17 1999 Registrar



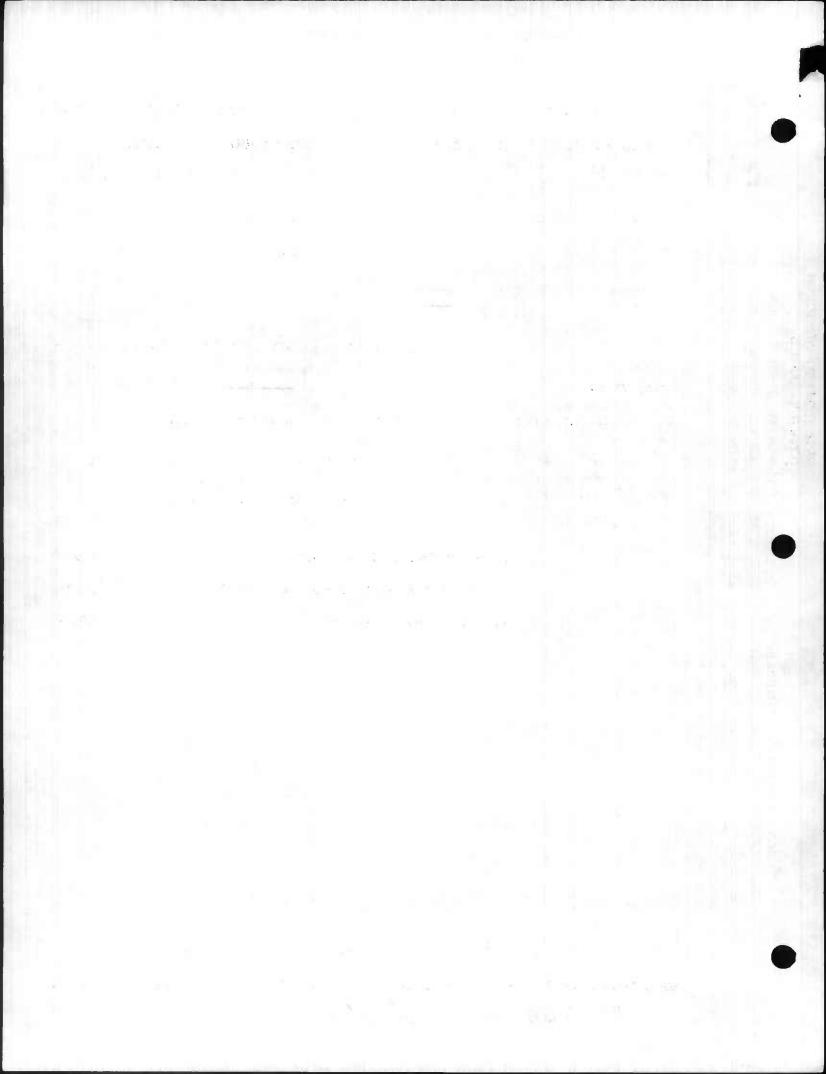
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18 State of Maryla	nd / Department of Health and	Mental Hygiene
Carroll County, wjl	Certificate of Death	Reg. No.
me (First, Middle, Last)		2. Data of Death

			ems 12 & 18 5/19/99, Carroll C	State of Ma ounty, wjl	arylan		partment of ertificate of		vientai Hy	/giene Reg. No.	1 *	123	4
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	Funeral		5. Social Security Number  6. Sex  218-26-3253  1 M 2 F  7. Age (In yrs. last birthday)  6. Sex  Yrs.  6. Sex  4 Months Days Hours Min.								ry)	or Foreign	
	Director	-	Usual Rasidence of Decedent		00				Apr 3	0,1931	Mary	Tallu	
G Z1Z15-00Z0 filed within 72 hours efter death with the Maryland Hygiene.	how #		10a. State 10b. County		10c. Cit	y, Town or	Location				10	d. fnside C	
	1	Director	Maryland Carro	011				Miller	S				2 No
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death	ma 23	Funeral						Hispanic Origin? (S	dispanic Origin? (Specify Yes or No- an, Maxican, Puerto Rican, etc.)		14. Race - American Indian,		
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rylan nould be 1 Mental narked o	2 D .	o Be	William Burton					Ruth		Ruth Hugh			
	and M s mari	-	19a. Informant's Name/Relationship (	Type, Print)		19b. M	eiling Address (Stree	et and Number or Ru	ural Route Num	ber, City or Town,	Stete, Zip	Code)	
Z 2	27 tr		Shirley Hughes, v	vife		500	5 Roller	Rd, Mille	rs, Md	21102			
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deeth cert	ettending p	lan		u									
ت ق ق	the e	Physician/Me	Part II. Other significant conditions of	ontributing to death be	ut not res	ulting In th	e underiying ceuse g	iven in Part I.		d tobacco uae co			
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5 8	E 6 D	ertification:	4 Homicide determined	Zoe. Place of Inju	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number. City or Town, State)						
pital	eral C	O	29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as steted.										
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,	2 - 0		5. Sodhi D42014					MAY 14, 1999					
		-	30. Name and address of person who	completed cause of d	eath (Iten	n 23a) (Ty		υ± <del></del>		LIMI TH	エフラブ		
			SURINDERPAL SODHI					CARE SYST	EM, PER	RY POINT	, MD	2190	2

State Registrar 31. Date filed (Month, Day, Year) MAY 17 1999

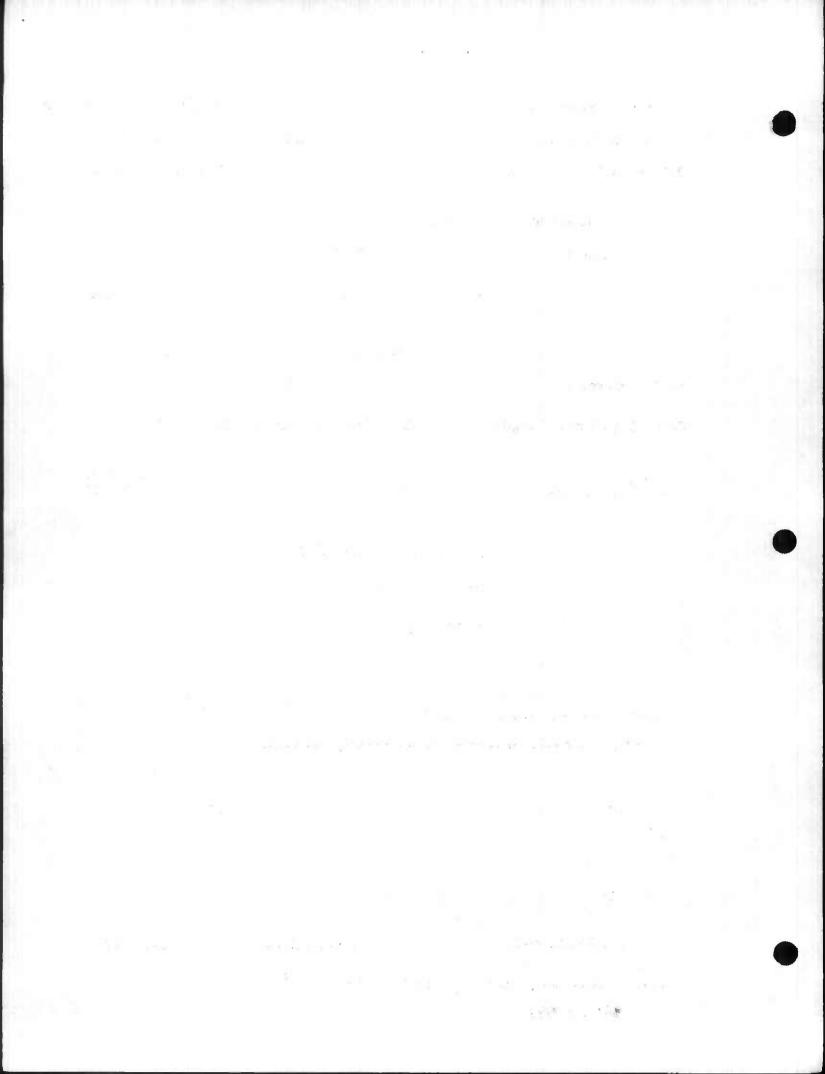
32. Registrar's Signature

G. Sparks

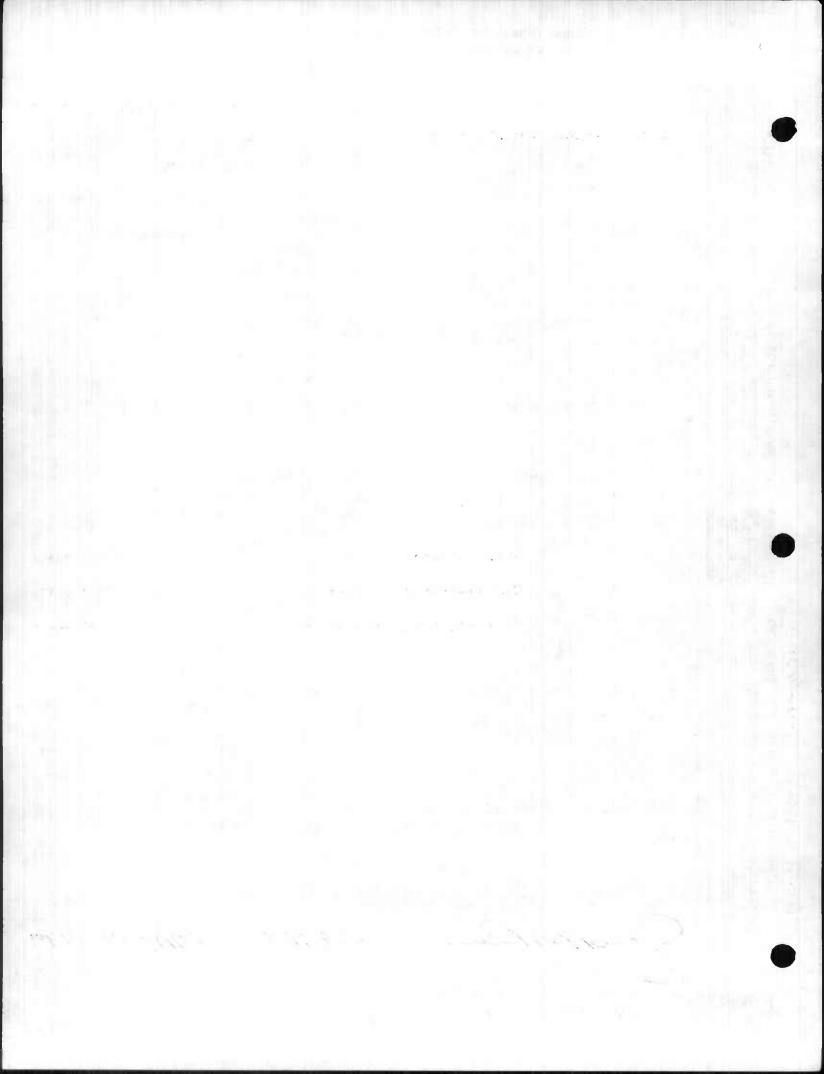


State of Maryland / Department of Health and Mental Hygiene

					,	Cer	tificate o	f Death	R	eg. No.	2 1	1.64		
П	Dhuala		1. Decedent's Name (First, Middle, Las	it)					2. Dete of Dea	th	Year	3. Time	e of Death	
	Physic /Medi		Mary Evelyn H	qme					5/17	/1999	1001	6:1	.7 AM	
	Exami		4e. Facility Neme (If not institution, give	street end number)				4b. City, Town, or	Location of Deeth	4c. County	of Deeth			
			65 Boston Dri	ve				Berlin		Wor	ceste	r		
	Funeral Director		217 10 7307	D	e (In yrs. last 78	birthdey) Yrs.	If Under 1 Yea Months Day			1921	9. Birthp Coun Mary	lace (Ste	te or Foreig	in
	aryland show		Usual Residence of Decedent  10a. Stete 10b. County		10c. City, To	own or Loc	cation				1		City Limit	
	Ne M	cto	MD Worceste	er	Ber1	lin						1 ∐ Y	es 2 GN	)
	# 9 #	Dire	10e. Street and Number				10f. Zip Code		1	0g. Citizen of \	What Coun	try?		
	23a	ra E	65 Boston Drive				2181	1		USA				
21215-0020	s 1 and 2 should be filed within 72 hours efter death with the Manyand I Health end Mental Hyglene. If Health end Mental Hyglene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Evanther must be notified at	by Funeral Director	11. Merital Status  1 □ Never Merried 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give X Yeer or Detes:			Ves Decedent of Yes, specify Cu ☐ Yes 2 No.		Specify Yes or No- rto Rican, etc.)	Biad	e - Americ ck, White, Whi	etc.	•	
2-0	72 ho	ted	15. Decedent's Ed	ucation	16	6a. Deced	ent's Usuai Occ	upetion e during most of wo	a de la c	16b. Kind of B	usiness/inc	lustry		
2	within and the second	Completed	(Specify only highest grade Elementary/Secondery (0-12)	College (1-4or 5	i+)	life. D	OO NOT use reti	e during most or wo red)	orking					
2	ogien Gien	00	12			Man	ager			Restau	rant			
Maryland	should be filed within and Mental Hygiene. s marked other than " numatic event, the Ma	Be (	17. Father's Name (First, Middle, Last)					18. Mother's Na	ame (First, Middle,	Meiden Sumen	10)			
<u>a</u>	uld b Ment rrked rtic e	To	Harley Ricketts					Zola	ı					
an	2 sho end 1 is me	ľ	19a. Informant'a Name/Relationship (7	ype, Print)	1	9b. Meilin	g Address (Street	et end Number or F	Rural Route Number	r, City or Town,	Stete, Zip	Code)		
	Health Health em 27 i		Susan Dian Furst-	daughter		65 B	oston D	r., Berli	n, MD	21811				
Baltimore,	of Hear		20a. Method of Disposition	-	20b. Piace ceme	of Dispos	ition (Neme of etory or other p			20c. Location -	City or To	wn, State	1	
Ĕ	Page nent int: If		1 ☐ Burlal 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify						5/17/00	Frankfa	and I	) F		
=======================================	permit. Pages 1 Department of I- Important: If ite any injury or ot once.		21. Signature of Funeral Service Licens	see	pape_i	22.	Name end Add	ress of Fecility	5/17/99	58 Will	iams	St.		
Ö	Depa impo any lr		VKAil B			Th	e Burba	ge Funera	1 Home Be	erlin,	MD	2181	.1	
			23a Fine Enlar to disease, or comp shock, or heart failure. List only	nications that caused	the death D	o not ente	or the mode of d	ring such as cardin	o or respiratory arr	net		Approxin	mata.	_
	Physician /Medical Examiner	J.	Immediate Cause (Final disease or condition resulting in death)	a	2rebro		etasta	1252				Interval I Onset ar	nd Deeth	
	ped jisit	Examiner	_	b	_	2-661		<u>-</u>						
	and and	xar	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying		Due to (or as	,	uenca of):				į			
20	be e ician burie	alE	Cause (Disease or Injury	c	Molcin	9								
Box 68760,	certificate be executed nding physician and use as the buriel-transit	n/Medical	that initieted events resulting In death) Last	d	Due to (or es	a consequ	ence of):							
ă	d for	cia	Pert II. Other significant conditions co	ntelbuting to death hu	it not reculting	n in the un	dadvina causa	tion in Dort I	22h Dide	obacco use co	ndelbuda da	the name	a of doot	2
л. О	that the deeth cer led by the attendir detached for use	y Physician/M								/			Unknow	
Division of Vital Records,	The iew requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the buriel-transit	Completed by	COPD (cwo	ic op11tn	ctive	pola	Prava	disease?	24e. Was a perfor		ava	ere autope allable pri mpletion d deeth?	sy findings or to of cause	
I		50							1 □ Y	es 2 No	1	Yes 2	DE No	
<u> </u>	rtifica stor,	Be (	25. Was case referred to medical					26. Place of De	eath (Check only or	16)				
>		To	examiner? 1 ☐ Yes 2 ☑ No	Hospitai: 1 ☐ Inpatier	nt 2 ER/	Outpatient	3 DOA	ther: 4 Nursing	Home 5 Reside	enca 6 DOth	er (Specify	()		
0	g Physical dispersion		27. Manner of Death	28e. Date of Injury	y 28t	. Time of	28c. lnj	ury et	28d. Describe h	ow Injury occur	red			
0	Attending or deeth.	atio	1 BNetural 5 Pending (Month, Dey Year) Injury Work? 2 Accident Investigetion M 1 Yes 2 N											
DIVIS	To the Hospital or Attending Phy within 24 hours after deeth. To the Funeral Director: After thi completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju- building, etc.	ry - At home, . (Specify)	farm, stre	et, factory, office							
	ne Hospi in 24 hour ne Funeri pletely fill	edical	29e. Certifier (Check only one)  Check only 2 Medical Example	raicien: To the best of Iner: On the basis of and menner stat	examination (	ige, death end/or inve	occurred et the estigation, in my	red at the time, date and place, and due to the cause(s) and manner as atated. ion, in my opinion, death occurred at the time, date and place, and due to the cause(s)						
	with!	ž	29b. Signature and title of certifier	29c. License number 29d. Dete signed (Month, Dey, Year)			100							
			DOOS1232 5.17.							1.99				
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)											
			10445 Ocean 6:			erlin		11815						
	Sta	te	31. Dete filed (Month, Dey, Year)	32. Registre	or's Signeture		1							-



	1. Decedent's Nama (First, Middla, Last	)	Certificate		2. Data of Deat		3. Time of Dea	
Physician /Medical	Elizabeth H	н.	Hutchinson	1	Month 05	Day 1019	Year 4:35 p	.m.
Examiner	4a Facility Name (If not institution, giva Memorial Hospital N			4b. City, Town, or L		4c. County		
				Cumberla ear   If Under 24 Hrs.			Allegany	
Funeral Director	5. Social Security Number  234-40-3463  Usual Residence of Decedent	7. Age (In yrs.		ays Hours Min.	8. Date of Birth Month, Day, 2.0	Year)	9. Birthplaca (State or For	raign
/land	10a. State 10b. County	10c. C	ity, Town or Location				10d. Inside City Li	mits
filed within 72 hours after death with the Maryland Hygiene. Hygiene.  ther than "natural", or items 23a or 28a-f show out, the Medical Examiner must be notified at e. Completed by Funeral Director.	MD Alleg	jany	Cumberla	ind			1 Yes 2	] No
or 28	10e. Street and Number		10f. Zip Co		1	0g. Citizen of V	Vhat Country?	
1 23a	220 Somerville			21502		USA		
al, or terms 23a or 28a-fa Evarriner must be notified by Funeral Director	11. Marital Status  1 Navar Married 2 Married  Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forcas? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	If Yes, specify	of Hispanic Origin? (S) Cuban, Mexican, Puerto No Specify:	o Rican, etc.)	Biad	e - American Indian, kk, White, etc. "white	
natural address Executed b	15. Decedent's Edu (Specify only highest gred	cation e completed)	16a. Decedent's Usual O	ccupation	kina	18b. Kind of Bu	siness/Industry	
i and Mental Hygiene. Is marked other than "natura raumatic avent, the Medical E TO Be Completed	Elementery/Secondary (0-12)	College (1-4or 5+)	Retired	one during most of wor etired)		вм		
merked other umetic svent, To Be C	17. Fathar's Name (First, Middla, Last)			The second secon	ne (First, Middle, I		е)	
T is marked othe traumatic avent,	Dewey Troutman  19a. Informant's Name/Relationship (Ty	me Print)	19b. Mailing Address (S	Minerva treet and Number or Bu		sher	State, Zip Code)	
27 ls r trau	Abraham Fisher	po, 1 1111y	Route 3 Bo	x 348; Ric	dgeley,	WV 26		
nt of Health I: If item 27 I	20a. Method of Disposition	Ramoval from Stata	Piaca of Disposition (Name cometery, crematory or other	r place)			City or Town, State	
Department of Important: If its any Injury or o	4 Donation 5 Other (Specify)  21. Signature of Funeral Service License	1.0	rt Ashby Ce	metery TTT Fune:			Ashby, WV	
Depar Impor any Ir	- MARIANS	1. Maural		land, Man		21502		
•	23a. Part1. Enter the disease, or compleshock, or heart feilure. List only be	ications that caused he dea	th. Do not enter the mode o	dying, such as cardiac	or respiratory arr	est,	Approximate Interval Between	0
hysician							Onset and Deat	n
Medical xaminer	Immediate Cause (Final disease or condition resulting in death)	Sepsis syn	drome				3 week	S
<u> </u>			or as a consequence of):					
an and rial-trensit	Sequentially list conditions		onary cachexi or as a consequence of):	a			1 year	-
urial-tr	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury		severe obstru	ction			20 200	c
physician and ss the burial-trensit	Cause (Disease or injury that initiated events resulting in death) Last		or as a consequence of):	CLOH			20 years	5
d for use es		d						
ed by the atte deteched for Physicia	Part il. Other significant conditions con	ntributing to death but not re-	sulting in the underlying caus	e given in Part I.	23b. Did to	obacco use co	ntributs to the cause of de	ath?
igned by be detect	ETOH abuse				124	'es 2□ No	3 Probably 4 Unk	nown
been s should					24a. Was a perfor	in autopsy med?	24b. Were autopsy findir available prior to completion of cause of death?	
page 2					1 🗆 Y	es 20 No	1 ☐ Yes 2 ☐ No	
ertific ector.	25. Was case referred to medical examiner?			1 -	eth (Check only or	76)		
T T	1 Yes 2 No		ER/Outpatient 3□ DOA		lome 5 Reside			
on on	27. Menne of Deeth Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	injury at Work? 1 ☐ Yas 2 ☐ No	28d. Describe h			
Direct d in by	3 Sulcide 6 Could not be 4 Homicide determined	28e. Piaca of injury - At h building, etc. (Speci	nome, farm, street, factory, o	ffice	28f. Location (S City or Town		oer or Rural Route Number,	
within 24 hours efter death. To the Funeral Director: A completely filled in by the filled and the filled and the filled in the	29a. Certifier Certifying Physics (Check only 2 Medical Examination)	sician: To the best of my knowner: On the besis of axeminand manner stated.	owledge, death occurred at t ation and/or investigation, in	he time, dete and piece my opinion, deeth occu	, and due to the c rred at the time, d	euse(s) end me date and place,	enner as stated. and due to the cause(s)	
Within To the comple	9b. Signature and title of certifier		290	icense number	2	29d. Date signe	d (Month, Day, Year)	
4	30 Name and eddress of person who co	rmolated cause of death fits		8769		TAY	14 1999	7
Mus	James Raver	Memorial H	ospital Cum	berland N	MD 2150	2		
State Registrar	31. Dete filed (Month, Dey, Year)  MAY 1 4 1839	32. Registrer's Sign	ature					
-3	11111 1000	W	A Shirt And Shirt	-				



1 M 2□ F

2. Dete of Deeth 3. Time of Deeth Dev May 18, 1999

2:22 pm 4c. County of Death

4b. City, Town, or Location of Death Cumberland All

If Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth
Months | Deys | Hours | Min. | Sep 5, 1927

**Allegany** Birtholece (Stete or Foreign Coulots)
 MD

> 10d. Inside City Limits Yes 2□ No

**Funeral** Director

with the Maryland r 28a-f show r than "natural", or items 23s or the Medical Examiner must be permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene, important: if Item 27 is marked other than "natural", or items 23a any linjury or other treumstic event, tre Medical Experimentable.

> **Physician** /Medical

Examiner

physician and s the burial-transit

attending p

signed by the a

has 10 2 certificate had The

this

After

eral Director: A

within 24 hours a To the Funeral Completely filled Hospital

To the

mu

death.

law requires that the death certificate be executed

Box 68760.

P.O.

Records,

Division of Vital or Attending Physician:

HOUSE

JOHN

Physician/Medicai Examiner

Py

Completed

Be

10

Certification:

edicai

altimore, Maryland 21215-0020

Director

Funeral

þ

Completed

213-22-3393 Usuel Residence of Decedent 10e. Stete 10b. County Allegany

5. Social Security Number

10e. Street end Number

10c. City, Town or Location

Yrs.

Cumberland 10f. Zip Code

1 ☐ Yes 2 ☐ No

Months

10g. Citizen of Whet Country? USA

224 Harrison Street

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes:

7. Age (In yrs. last birthdey)

71

 Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Specify:

21502

14 Rece - American Indian Bleck, White, etc. Specify: white

1 Never Merried 2 Merried Widowed 4 ☐ Divorced

15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+)

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)

Retired Bd of Education Washington County

20c. Location - City or Town, State

16h. Kind of Business/Industry

17. Father's Neme (First, Middle, Last)

John J. House

Elementary/Secondary (0-12)

18. Mother's Neme (First, Middle, Maiden Sumeme) Florence M (Humbertson)

19a. tnforment's Neme/Reletionship (Type, Print) Charles P. House

20b. Piece of Disposition (Name of cemetery, cremetory or other piece)

19b. Malling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code)
Rte 3 Box 273; Berkeley Springs, WV 25411

SON 20a. Method of Disposition

1 Buriel 2 □ Cremetion 3 □ Removel from State 4 ☐ Donation 5 ☐ Other (Specify)

Peter Paul Cemetery5/21/ Cumberland, MD Scarpersof Funeral Home P.A.

Cumberland, Maryland 23a. Pert1. Enter the disease, or comblicehols that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset end Deeth

tmmediate Cause (Finel disease or condition resulting in death)

Chronic Obstructive Pulmonary Disease Due to (or es e consequence of):

10 years

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest

Due to (or es e consequence of)

Due to (or es e consequence of):

Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert i.

23h. Did tohacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Wes an autopsy

24b. Were autopsy findings aveilable prior to completion of cause of death?

1 Yes 2 Ho

1 ☐ Yes 2 ☐ No

25. Wes cese referred to medical 26. Plece of Death (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specity)

1 Yes 20 No 27. Menner of Deeth 1 Neturel 2 Accident

5 Pending investigation 6 Could not be determined 2-RER/Outpatient 3 DOA

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier

3 Suicide

4 Homicide

Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the ceuse(s) and menner as stated.

Medical Examinar: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) end menner stated.

29b. Signeture end to of partifier

29c. License number 033280 29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Dr. Sunil Gupta, Johnson Heights Medical Bldg., Cumberland, MD

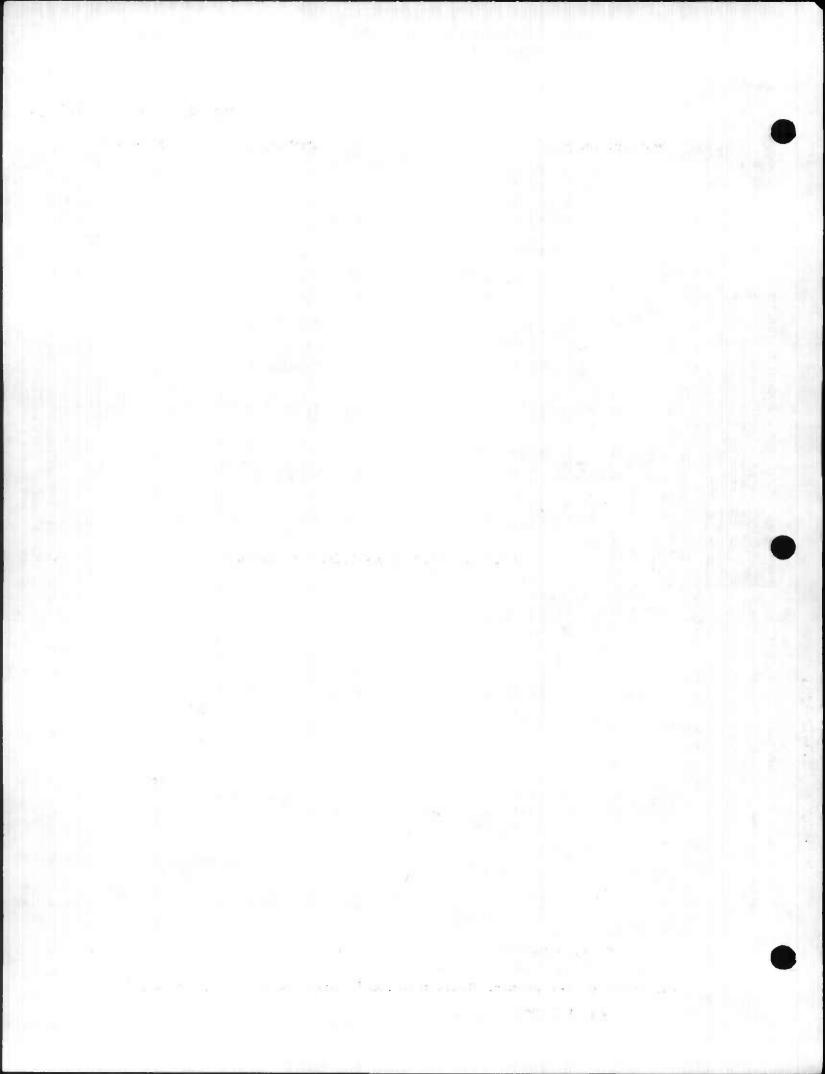
Registrar

a

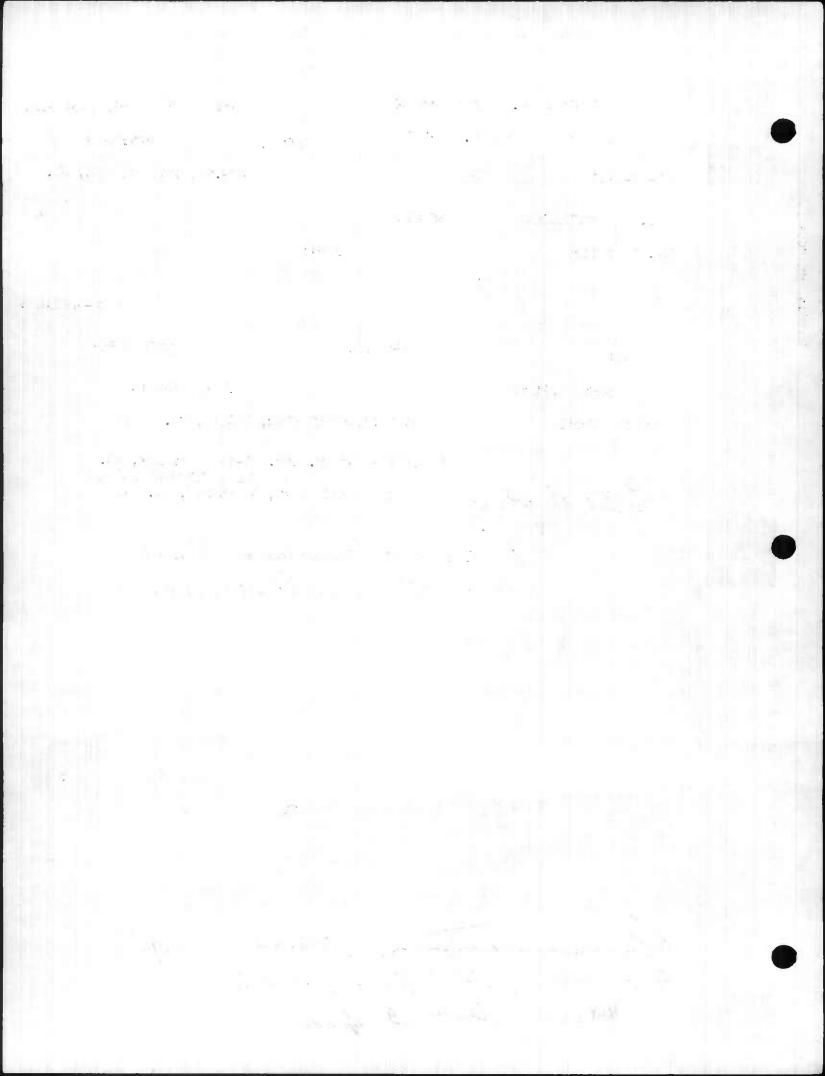
31. Dete filed (Month, Dey, Year) MAY Z O



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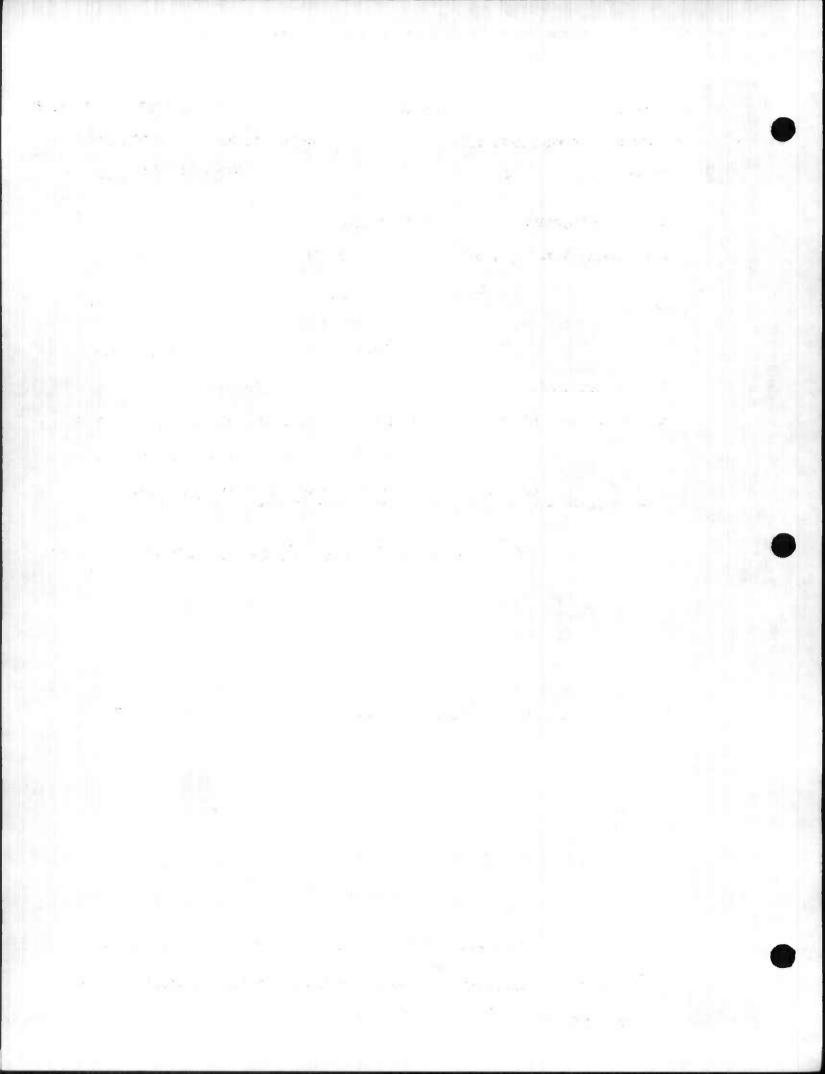


4 D	dandla Ninasa	(First, Middle, I	(4)							2. Date of De	a a the		2 Ti-	ne of Death
an al		REBECC	CA E.	SPENCI	E H	ARMON				MAY MAY	9,	Yeer 199	9 6:3	O P.M.
er <sup>4a Fecil</sup>		not institution, g IN NURSI	-	-	CEN	TER				Location of Dea		ounty of Dea		
5 Social	Security No		S. Sex			ast birthday)	If Under 1		BERLIN If Under 24 Hr	8 Date of Bi		VORCES		ate or Foreig
220	-01-71	257	1□ M 20		(117)10.10	Yrs.	Months E	Days	Hours Mir	8. Date of Bi (Month, D AUG • 10	, 1910	) NEW	ARK,	MD.
10a. Sta		10b. County		1	10c. City,	Town or Loca	ation						10d. Insl	de City Limits
M S	D.	WORCES	STER		BE	RLIN							1 🗆	Yes 2 No
=	eet and Num			,			10f. Zip Co				10g. Citize	n of What Co	ountry?	
RTE	. 50	½ 113						2181			US			
		ed 2 Married	d 1 🗆	s Decedent Ev ned Forces?   Yes 2 \( \) No es, Give			es Deceden Yes, specify	V	panic Origin? ( Mexican, Pue Specify:	Specify Yes or N to Rican, etc.)		Black, Whi		in,
3 🗆 X	Widowed	4 Divorced	Yes	ar or Dates:		- 1	L 195 2L	7 140	эреспу.		5/	AF	RO-AN	ERICA
Eleme		15. Decedent's ify only highest g		leted)		16e. Decede	ind of work	Occupati done du	ion ring most of w	orking	18b. Kind	of Business	/Industry	
Eleme	entary/Secon		Coll	lege (1-4or 5+)	)		STIC	retirea)			HOU	SEKEEP	PER	
17. Fath	er's Name (	First, Middle, La	ast)		1	1700		1	8. Mother's No	me (First, Middle	, Meiden Su	meme)		
			SPENCE							ELIZA	STUR	GIS		
19a. Info		me/Relationship				19b. Mailing	Address (S	Street en	d Number or F	Tural Route Numi			Zip Code)	
T	HELMA	PURNELI	L.			8501	IRONS	HIRE	ROAD.	BERLIN,	MD.	21811		
	thod of Disp				20b. Pla	ace of Disposi metery, creme	ition (Name etory or othe	of er placa)		Date	20c. Loca	tion - City or	Town, Sta	te
		☐ Cremation 3 5 ☐ Other (Spec		I from State		CALVA				5-14	NEWA	RK, ME	).	
21. Sign	sature of Fur	nerel Servica Lig	Opnsed)		-		Name and A			OLLEY ME				
	Lui	Ma B	V has	00				CEN	DOAD	CALTODIL	N MD	2180	11	
immedia diseese resulting	ate Ceuse (I or condition in deeth)	Final	V			. Do not enter	r the mode o	of dylng,	such as cerdi	SALISBUF ac or respiretory	arrest,		Appro	dmete I Between and Deeth
immedia disease resulting  E Sequent if any, le cause. Cause (Cause (that initial trials)	ate Ceuse (I	Final  Inditions, mediete tlying	V	NSIE	ue to (or	. Do not enter	r the mode of the	of dylng,	such as cerdi		arrest,		Appro	dmete I Between and Deeth
immedia disease resulting  Sequent if any, le cause. Cause (that initial resulting res	ate Ceuse (I or condition g in deeth) tially list consading to im Enter Under Disease or I ated events	Final  Inditions, mediete tlying njury	V	NSIE	ue to (or	ENSTICE es e consequ as e consequ	r the mode of the	of dylng,	such as cerdi	c or respiretory	arrest,		Appro	kimete I Between and Deeth
Immedia disease resulting Sequent if any, le cause, Cause ( that initial	ate Ceuse (I or condition g in deeth) tially list con adding to im Enter Under Disease or I ated events g in death) L	Final  Inditions, mediete tlying njury	a	NSU DI	ue to (or ue to (or or	es e conseques e conseques e conseques e conseques e conseques e conseques es e c	r the mode of the	of dylng,	Such as cerdi	AL COMPANY OF THE PROPERTY OF	NEW tobacco un	SC (CV)	Appro- Interve Onset	use of death
Immedia disease resulting Sequentification of fany, le cause Cause that initial resulting Part II. O	ate Ceuse (I or condition g in deeth) tially list con adding to im Enter Under Disease or I ated events g in death) L	Final nditions, mediate thying injury	a	NSU DI	ue to (or ue to (or or	es e conseques e conseques e conseques e conseques e conseques e conseques es e c	r the mode of the	of dylng,	Such as cerdi	AL COMPANY OF THE PROPERTY OF	NEW tobacco un	8E (V)	Appro- Interve Onset	use of death
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Immedia disease resulting  Sequentifi any, le cause. Cause (that initimesulting)  Part II. O	ate Ceuse (I or condition g in deeth) tially list con adding to im Enter Under Disease or I ated events g in death) L	Final nditions, mediate thying injury	a	NSU DI	ue to (or ue to (or or	es e conseques e conseques e conseques e conseques e conseques e conseques es e c	r the mode of the	of dylng,	Such as cerdi	23b. Dic	MELL  tobacco us  tobacco us  sen eutops; ormed?	Sc (CV)  se contribut  No 3 F	Appro- Interve Onset  Interve Onset	use of death  45.Unknown  psy findings  prior to  n of cause
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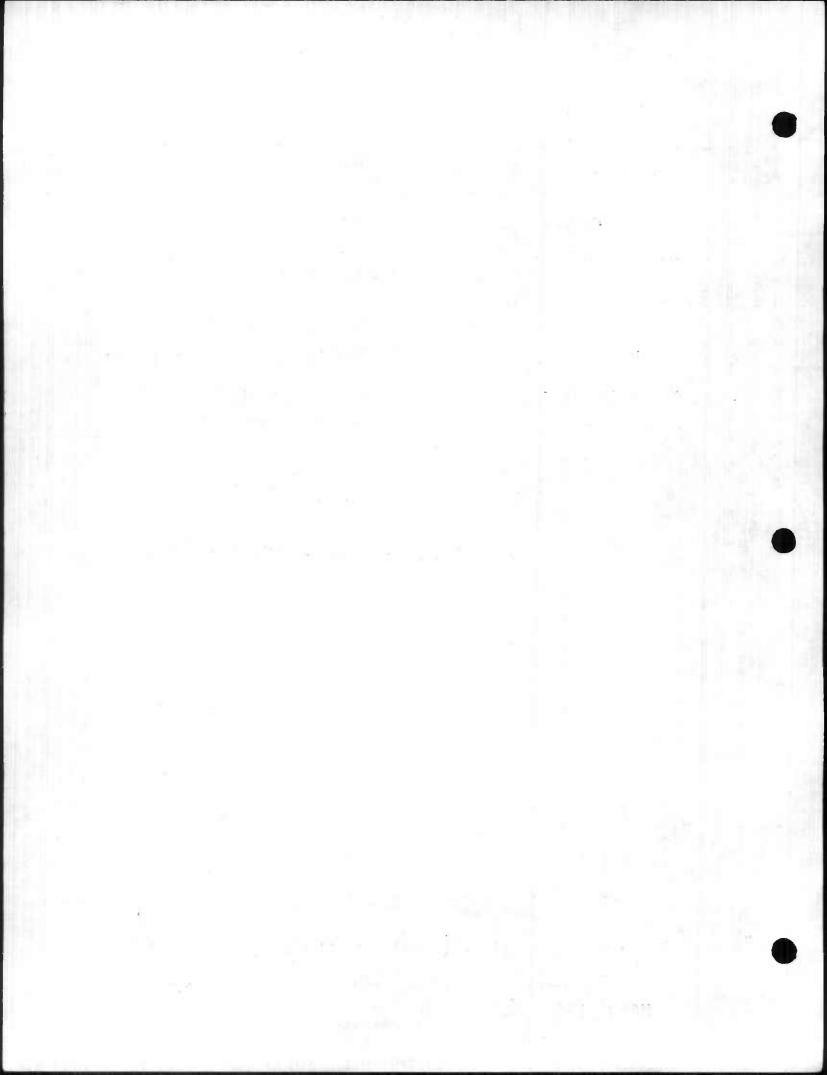
State of Maryland / Department of Health and Mental Hygiene

		•	Certificate of	Death		Reg. No.	1.12	3.9
District Control	1. Decedent's Name (First, Middle, i	ast)			2. Date of Dea	ath Day	Yeer 3. Tir	me of Death
Physician /Medical	HELEN B.	HA	MILTON			3, 1999		:15 AM
Examiner	4a Facility Neme (If not institution, g	rive street and number)		4b. City, Town, or	Location of Death	4c. County	of Death	
	211 RUSSELL AVEN	JE, APT. #319		GAITHERS			COMERY	
Funeral Director	5. Social Security Number  491–18–9338  Usual Residence of Decedent	Sex 1 M 2 F 88	. last birthday) If Under 1 Yea Months Days		8. Date of Bird (Month, Da Sept.	21,1910	9. Birthplace (Si Country) Illinois	tate or Foreig S
3=	10a. State 10b. County	10c. C	ity, Town or Location				10d. Insi	ide City Limit
natural, or items 23s or 28s-f show dies Examiner must be notified at steed by Funeral Director	MD Montgo	mery	Gaithersburg			40		Yes 2□N
Dir	10e. Street and Number	3	10f. Zip Code			10g. Citizen of V		
eral	211 Russell Ave	12. Was Decedent Ever in t	208		posity Vac or No	U.S.	A. e - American India	en
"natural", or items 23 edical Examiner must leted by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3.□ Widowed 4 □ Divorced	Armed Forces?	J.S. 13. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2010		o Rican, etc.)	Biad	ok, White, etc. White	
ed le	15. Decedent's	Education	16a. Decedent's Usual Occu	upation			usiness/Industry	
	(Specify only highest	rade completed)	(Give kind of work done life. DO NOT use retir	e during most of wo red)	rking			
r than	Elementery/Secondary (0-12)	College (1-4or 5+)	Agent			Real E	state	
Mental Hygiene.  Brice ovent, man  To Be Comp	17. Father's Name (First, Middle, La			18. Mother's Na	ne (First, Middle,	Malden Sumam	10)	
marked imatic ev	John C. Brisser	nden		Berth	a York			
r is marke treumatic	19a. Informant's Name/Relationship	(Type, Print)	19b. Meiling Address (Street			er, City or Town,	State, Zip Code)	
	Elbert R. Shore	e (Son)	7404 Miller	Falls Rd.	, Rockv	ille, MD	20855	
mportant: if item 27 in in in item 27 in ite	20a. Method of Disposition	20b.	Place of Disposition (Name of cemetery, crematory or other pl		Date		City or Town, Sta	ite
	1 Burial 2 Cremation 3 4 Donation 5 Other (Spe		A. Ferris & Co		5/18/99	West Ch	ester. I	ΣΔ
important: I any injury o ance.	21. Signature of Funguel Service Lic		22. Name and Add		0,.0,00		1000027	
any and	11/1	011		Cargo Fur Marylar	eral Hor	ne, P.A.		
	" formety	Di Garge	Aberdeen	, Marylar	d 2100°	1-3399		ularata
	23a. Pert1. Enter the disease, or co shock, or heart failure. List on	ly one cause on each life.	ith. Do not enter the mode of dy	ying, such as cerdia	c or respiratory e	rrest,	Interv	xlmate al Between and Death
sician		-0	10 + 1	00		0	Oliser	and Death
edical miner	Immediate Cause (Final disease or condition	a Chroni	i abstructi	r lul	house	Mean	ye	an
	resulting in death)	Due to (	or es e consequence ot):					
ine sit		- h						
ial-transit Examiner	Sequentially list conditions,	Due to (	or as a consequence of):					
	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury	0						
provided and its the bunkl-transit edical Examir	that initiated events resulting in death) Last	Due to (	or as a consequence of):					
2 8								
etached for use		d						
ed for	Part II. Other significant conditions	contributing to death but not re	sulting in the underlying cause g	given in Part I.	23b. Did	tobacco uae co	ntribute to the ca	uae of deat
be detached by Physic	012 1	1. 17.	1 Avreau		10	Yes 2 No	3 Probably	4 Unkno
be de	allerord	no lea	Iviear					
d blu						en eutopsy	24b. Were auto	
page 2 should					pend	ormed?	available properties of deeth?	n of ceuse
Page 2						V 0171		
Pa O						Yes 210 No	1 Tes	2 LI NO
Be Co	25. Was cese referred to medical exeminer?	Hospital:		Whor:	ath (Check only			
E P	1 ☐ Yes 2 € No	1 Inpatient 2L	ENOutpatient 3LI DOA	4 🗆 Nursing i	lome 5 X Resi			
	27. Menner of Deeth  1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of lnjury W		28d. Describe	how injury occur	red	
Director: Afferd in by the fune fune fune fune fune fune fune fun	2 Accident investigat	he		☐ Yes 2 ☐ No				
d T	3 ☐ Suicide 6 ☐ Could not determine		nome, farm, street, factory, offici ify)	ө	28f. Location ( City or To	Street and Numb wn, State)	ber or Rural Route	Number,
Se Se								
completely filled in by the Medical Certific			owledge, death occurred at the etion and/or investigation, in my					use(s)
No.	29b. Signature and title of certifier	111		nse number	/	29d. Date signe	d (Month, Day, Yo	ear)
0	D ()-11	& helmon	19.0	205/6		MAV 12	1000	
	20 Nomeron of	a completed across of death fits	m (2a) (Tuno Print)			MAY 13	, 1777	
	30. Neme end address of person wh			DOAD DE	HECDA 3	(ADS/T AS/P	2001/	1700
	JOEL R. SCHULMAN		LD GEORGETOWN	KUAD, BET	HESDA, N	IAK I LAND	20814-	1700
State	31. Date filed (Month, Day, Year)	32. Registrar's Sign		4 .				
egistrar	MAY 1 8 19	199 Devens	D. Sport	0				
mu cme			/					



an	1. Decedent's Ma	me (First, Middle, Last	1)						2. Date of De		Voor	3. Tima of Death
al		e Elliott H							May		999	9:44 ar
r		(II not institution, give							Location of Deat			
	108 McS 5. Social Security	Spadden D		(In yrs. I	last birthday)	If Under 1	Year Hi	Jnder 24 Hrs.	8. Dete of Bir (Month, De	Harfo		place (State or Fore
	220-03- Usuel Residence	-6376 <sup>10</sup>	TM 2/VE	77	Yrs.	Months D	Days H	ours Min.	10/08/	1921	PA	place (State or Foreintry)
	10a. State	10b. County		10c. City	, Town or Loc	cation					1	Od. Inside City Limi
	MD	Harford	d l	Hav	re de	Grace	2					1 XYes 2□N
	10e. Street and N	lumber				10f. Zip Co	ode			10g. Citizen of V	What Cour	ntry?
		Spadden D				2107	_			USA		
		erried 2 Married  4 Divorced	12. Wes Decedent E Armed Forces? 1  Yes 2 No. If Yes, Give Year or Dates:	o in U,	H	Was Decedent Yes, specify	Cuban, M	nic Origin? (S exican, Puert pecify:	pecify Yes or No o Rican, etc.)		ck, White,	
l	(Spi	15. Decedent's Edu	ucation le completed)		16a. Deced	lent's Usual C kind of work of OO NOT use i	Occupation	a most of wor	kina	16b. Kind of B	usiness/Inc	dustry
	Elementary/Sec	condary (0-12)	College (1-4or 5-	+)								
	6th	e (First, Middle, Last)			Н	lomema		Mother's Nar	ne (First, Middle	Home Maiden Suman	ne)	
			hh							Meddlir		
		Luther_We			19b. Mailin	ng Address (S				er, City or Town,		Code)
	David E	Iliott- Son			PO B	lox 351	Per	rvville	, MD 2	1903		
	20a. Method of Di	isposition			lace of Dispos	sition (Name	of	1	Date	20c. Location -	City or To	own, State
		2 ☐ Cremation 3 ☐ F 5 ☐ Other (Specify)			k Run			1!	5/7/99	Havre o	de G	race, MD
	Dux	Funeral Service Licens	1. Sin	H	Mi 12	3 S. W	Smit! Vashi	r Fune	Havre	ne, P.A. de Grad	ce, M	MD 21078
									or respiratory a			Approximete Interval Between
	Immediate Cause disease or condit resulting in death	tion			カナIA ras a consequ	c Pi			y FIB		 	Onset and Death
	disease or condit resulting in death  Sequentially list of if any, leading to cause. Enter Unic Cause (Disease of	conditions, immediate deriying or Injury	b	Due to (or		L Pu						Onset and Death
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	disease or condit resulting in death security in death security is an experience of the cause. Enter the cause (Disease that initiated ever resulting in death security in dea	erred to medical  No ath  5 Panding investigation to be	b	Due to (or  Due to (or  t not result  Year)	r as a consequence as a	uence of):  uence of):  uence of):  uence of):  adderlying cause  at 3 □ DOA  28c.  M	26. Other: Unity at Work?	Part I.  Place of Dec	23b. Did 10 24a. Was performent of the control of t	tobacco use co Yes 20No  an autopsy orned?  Yes 20No idence 6 0th how injury occur	3 Prol	o the cause of death  the the the the the the the the the the
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Medical Certification: To Be Completed by Physician/Medical Examiner	diseese or condit resulting in death  Sequentially list of sny, leading to cause. Enter Unicause (Disease of that initiated ever resulting in death  Pert II. Other sign  25. Was case referenced by the cause of the	erred to medical  No  ath  5 Pending investigation 6 Could not be determined  Secretifying Physical Examination of the condition of the condition of the could not be determined.	Hospitel: 1 Inpatier  28a. Date of Injung (Month, Day)  28e. Place of Injung building, etc.  sician: To the best of the part of the pass of the part of the pass of the part of the pass of the part of the pass of the part of the pass of the part of the pass of the part of the pass of the part of the pass of the part of the pass of the part of the pass of the part of the pass of the part of the pass of the part of the pass of the part of the pass of the part of the pass of the part of the pass of the part of the pass of the pass of the part of the pass of the part of the pass o	Due to (or Due to (or Due to (or or ot not result of not result)  Year)  If my know examinated.	r as a consequence as a	t 3 DOA  M Peet, factory, o	se given in  26. Other: Injury at Work? 1 Yes	Part I.  Place of De.  Nursing h	23b. Did 1   24a. Was perfet 1   ath (Check only lome 50 Resil 28d. Describe 28f. Location (City or To	tobecco use co Yes 20 No san autopsy ormed?  Yes 20 No one) idence 6 Oth how injury occur  Street and Numb wm, Stete)  cause(s) and me date and place,	24b. Wave coordinate (Special rand ber or Rura anner as s and due to	o the cause of death the the the the the the the the the the

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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Death 3. Time of Death MARTIN MANdy MAU 999 1231 John 4c. County of Deat 4b. City, Town, or Location of Death 4a Facility Nama (If not Institution, give street end number) Havre de Grace Harford Memorial Hospital Harford If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. 5. Social Sacurity Number 6. Sex 7. Age (In yrs. lest birthday) Birthplaca (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) 1₩ 2□F 74 Oct. 6, 1924 North Carolina 219-16-8125 Usual Rasidance of Dacedent 10c. City. Town or Location 10d. Insida City Limits 10a Stete 10b. County Maryland 1 Yas 20 No Harford Bel Air 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 2024 Churchville Road 21015 USA 12. Wes Decedent Ever In U,S. Armed Forcas? Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amaricen Indian, 11 Marital Status Black, Whita, atc 1 ☐ Yas 2 ☑ No If Yas, Giva Yeer or Datas: 1 ☐ Never Married 2 ☑ Married Specify: White 1 Yas 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grade completed) Automotive Parts Elamentary/Secondary (0-12) Collega (1-4or 5+) Sales Sales Manager 18. Mothar's Nama (First, Middle, Maiden Sumeme) 17. Fathar's Nama (First, Middle, Last) John Martin Handy, Sr. Viola (UNK) Bell 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 2024 Churchville Road, Bel Air, MD 21015 Mary Valerie Handy/Wife 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a, Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from State 4 ☐ Donetion 5 ☐ Othar (Specify) Mt. Zion U. M. Cemetery 5/7/99 Bel Air, MD 22. Neme and Address of Facility Howard K. McComas III Funeral Home, P.A. 21. Signatura of Funaral Sarvice Licanses 23a. Part 1. Enter he disease, or complications, that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or haart failure. List only one cause on each line. Approximate Intarval Between Onsat end Deeth Immediata Causa (Final disease or condition resulting in death) Ventricular Fibrillation Sudden Sequantially list conditions, if any, laeding to immadiata ceusa. Enter Underlying Causa (Diseasa or Injury that initiated evants rasulting in daeth) Last Dua to (or as e consequence of) Dua to (or es a consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Coronary Artery Disease 24a. Was an autopsy performad? 24b. Ware autopsy findings avelleble prior to Hyper cholesterolemia completion of ceusa of death? 1 Yas 2 No 1 Yes 2 No 25. Wes case referred to medical exeminer? 26. Placa of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Othar: 4 Nursing Homa 5 Presidence 6 Othar (Specify) 1 Yas 2 No

attending physician and I for usa as tha burial-trensit Box 68760, P.O. Division of Vital Records, aftar daath.

Director: Aft

Physician/Medicai by Completed Be

Examiner Certification:

**Physician** 

/Medical

Examiner

Directo

Funeral

by

**Funeral** 

Director

7 is marked other than "natural", or flems 23s or 28a-f ahow traumstic event, the Medical Examiner must be notified at

permit. Pagas 1 and 2 Depertment of Haalth a Important: If Item 27 Is any Injury or other trau

**Physician** /Medical

Examiner

Baltimore, Maryland 21215-0020

HAND

27.	Manner of Deeth
	1 Anatural
	2 Accident

3 Suicida

4 \ Homicide

5 Panding invastigation 6 Could not be datarmined

28a. Data of Injury (Month, Dey Year) 28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify)

28b. Tima of

28c. Injury et Work? 1 Yas 2 No

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the cause(s) and mannar as stated.

| Madical Examiner: On the basis of examination and/or invastigation, in my opinion, daeth occurred at the time, dete and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier

CAD

29c. Licanse number D35012 29d. Dete signed (Month, Dey, Year) May 6, 1999

30. Nama and address of person who complated causa of deeth (Item 23e) (Type, Print)

J. Kevin Cynch 31. Data filad (Month, Dey, Year)

2 North Ave Bel Air, Md. 21014

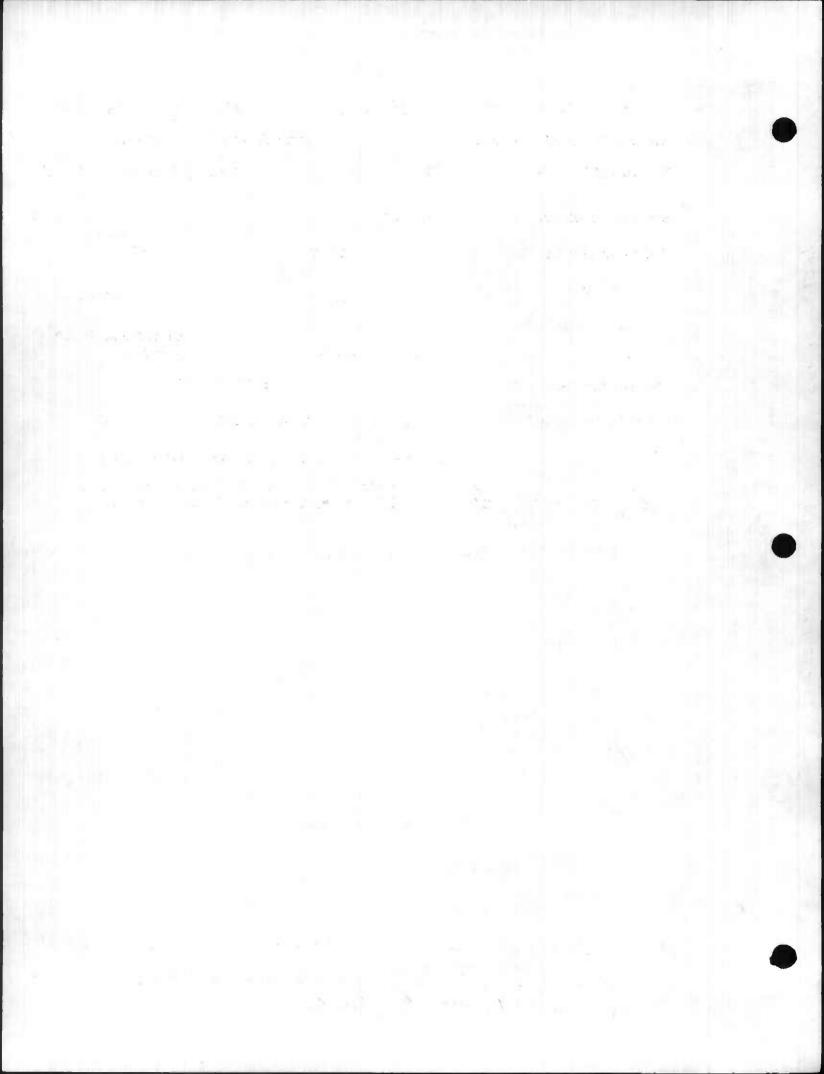
State Registrar

Medical

32 Registrer's Signatura

24 hours a

To the Within 2



State of Maryland / Department of Health and Mental Hygiene

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2	3  Widowed	4 Divorced	If Yes, Give Year or Date	es:		1 LI Yes	2√ No	Specify:		Specif	v: Wh	ite
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Ē	4 Homicide	determi	building	, etc. (Speci	ify)	, street, ract	ory, orrice		City or To		0, 0, 1,	
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edicai	(Check only one)		Phyeician: To the be examiner: On the basi end manne	s ot examina								
Mec	29b. Signature an	nd title of certifier	ond maine	stotou.	_	2	9c. Licen	se number		29d. Date signe	ed (Month	, Dav. Year)
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year 1999 ROSE 9:41 PM HANLE April 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street end number) Fallston General Hospital Fallston Harford If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Months Days Hours Min 1 □ M 200 Yrs. Nov. 1, 1923 New York Usual Residence of Decedent 10h Count 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Harford Joppa 10f. Zip Code 10g. Citizen of What Country? 428 Trimble Road 21085 USA 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 No if Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether'a Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) (nmn) Mary Mullen (nmn) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) William O. Hanle - Husband 428 Trimble Road, Joppa, Maryland 21085 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☐ Buriai 2 ICremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Hilltop Service Corp. 5/3/99 Towson, Maryland 22. Name and Address of Facility
Howard K. McComas III Funeral Home, P.A. 21. Signeture of Funeral Service Licensee 1317 Cokesbury Rd., Abingdon, MD 23a. Part1. Enter the disease, or complication that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only or cause on each line. Approximate Interval Between Onset and Death Marsine Fulmonary Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No

**Physician** /Medical Examiner

physician and the burial-transit

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page 2 certificate has

After this

death.

8 Hospital

after deat Director:

24 hours after Funeral Directors eletely filled in b

To the Hosp within 24 ho To the Fune completely fi

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that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Hanle, Marie Rose

Examiner

Physician/Medical

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Completed

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To

Certification:

Medical

4 Homicide

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Heath and Mental Physiene. Department of Heath and Mental Physiene important: If item 27 is marked other then "natural; or items 23s or 28s-f show any injury or other traumatic event, in Medical Examinar insures to notified at

Baltimore, Maryland 21215-0020

MARIE

5. Social Security Number

084-12-1580

10e. Street and Number

10a State

Maryland

Louis

20a. Method of Disposition

Directo

Funeral

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Completed

Be

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that inflieled events resulting in deeth) Last

Immediate Cause (Final disease or condition resulting in death)

Part II, Other significant	onditions contributing to death but not resulting in the underlying cause given in Pa

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No

25. Was cese referred to medical examiner? 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred

1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

29a. Certifier

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(s) and manner stated. (Check only one)

29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 39170

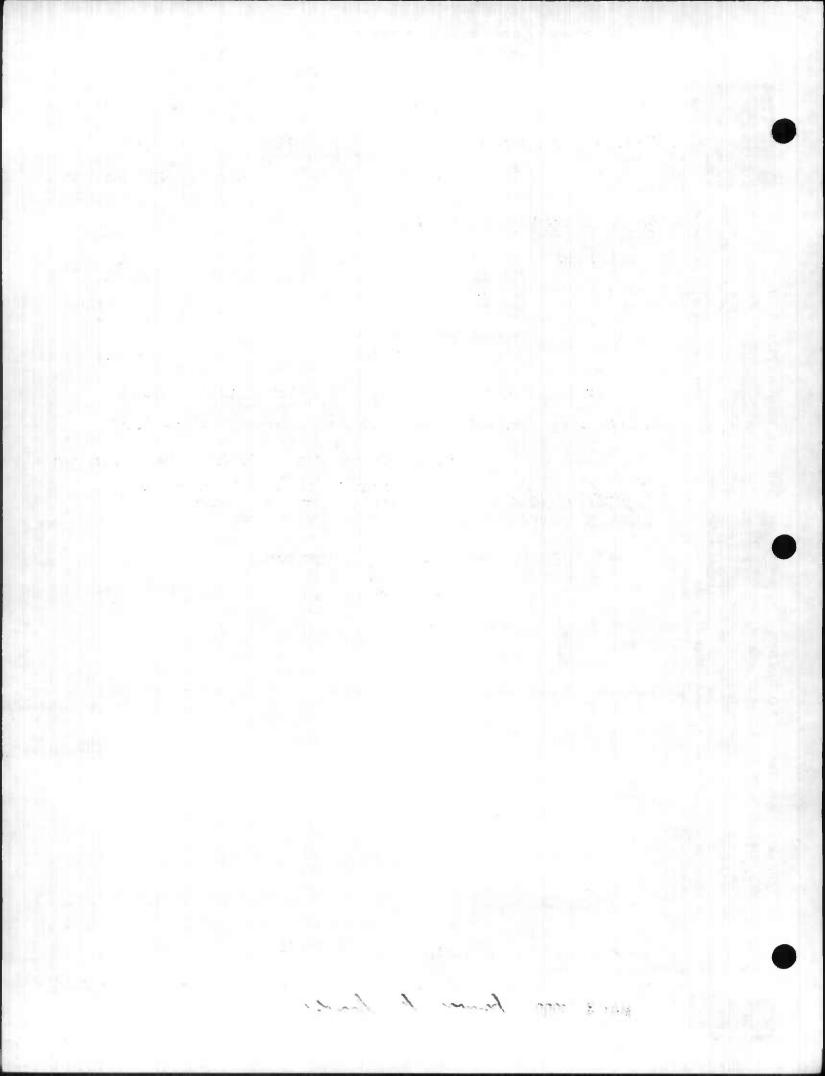
30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

MO

INTENSIVIST

200 Milton Avenue (Fallston General Hospital) Fallston, Maryland 21047 mathur

Registrar



State of Maryland / Department of Health and Mental Hygiene

									Death			Reg. No.				
1. Deceden	it's Name (First, Mic	ddle, Last)									2. Date of De Month	eath Day	Ye	ear	3. Time	f Dear
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5. Social Se	ocurity Number	6. Sex		7. Age (In	yrs. last bir	rthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	rth	9.	Birthpla	ce (State	or Fo
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10e. Street	and Number						10f. Zip					10g. Citize	en of Wha	t Countr	y?	
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1   Mature   2   Accident   3   Suicide   4   Homicide   4   Homicide   5   Pending investigation   3   Suicide   4   Homicide   4   Homicide   4   Homicide   5   Pending investigation   3   Suicide   4   Homicide   4   Homicide   5   Pending investigation   6   Could not be determined   28e. Pieca of Injury - At home, farm, street, fectory, office   28f. Location (Streat and Number or Rural Route Number, City or Town, State)   29a. Certifier   Check only one)   29a. Certifier   Check only one)   29b. Signatura apd fitta of certifier   29c. License number   29d. Date signed (Month, Day, Year)   29d. Date filled (Month, Day, Year)   32. Registrer's Signeture   31. Date filled (Month, Day, Year)   32. Registrer's Signeture   33d. Date filled (Month, Day, Year)   32. Registrer's Signeture   33d. Pate filled (Month, Day, Year)   32d.	00				1 6				JA	4 LI Nursing H				fy)
30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print)  DAVID 6AK-EL 3 MAULOIN AVENUE NORTH EAST MAKILAND 21901  State 31. Date filled (Month, Day, Year)  32. Registrer's Signeture	fter the nere	27		7 Pending	28e. Dete (Moi	of injury oth, Day Yea	28b. Tin	ne of 2	8c. injur Wor	y et rk?	28d. Describe	how injury occur	red	
30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print)  DAVID 6AK-EL 3 MAULOIN AVENUE NORTH EAST MAKILAND 2 (190)  State 31. Date filled (Month, Day, Year)  32. Registrer's Signeture	or: A he fu		2 Accident	investigati				М	10	Yes 2 □ No				
30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print)  DAVID 6AK-EL 3 MAULOIN AVENUE NORTH EAST MAKILAND 21901  State 31. Date filled (Month, Day, Year)  32. Registrer's Signeture	rect rect				286. Piec	a of Injury -	At home, farm	n, street, fectory	, office				ber or Run	al Route Number,
30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print)  DAVID FAK-EL 3 MAULOIN AVENUE NORTH EAST MAKILAND 21901  State 31. Date filled (Month, Day, Year)  32. Registrer's Signeture,	Sed in Die													
30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print)  DAVID FAK-EL 3 MAULDIN AVENUE NORTH EAST MAKILAND 21901  State 31. Date filled (Month, Day, Year)  32. Registrer's Signeture,	24 hour Funer etely fill dical	2	(Check only 2 ]	Cartifying P Medical Exa	miner: On the t	basis of exam	knowiedge, d ninetion end/	death occurred or investigation	at the tir , in my o	me, dete end pieca pinion, death occu	, end due to the rred at the time,	cause(s) and modele and piece,	enner as s and due t	stated. o the cause(s)
30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)  DAVID 6AK-EL 3 MAULOIN AVENUE NORTH EAST MAKILAND 2 (190)  State 31. Date filled (Month, Day, Year)  32. Registrer's Signeture	ithin of the omple		9b. Signatura apd fitia o	of certifier	,,			290	. Licens	e number		29d. Date signe	d (Month,	Day, Year)
30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print)  DAVID FAK-EL 3 MAULDIN AVENUE NORTH EAST MANLAND 21901  State 31. Date filled (Month, Day, Year) 32. Registrer's Signeture	s i o		· /11	5	MD			0	100	47711		Ma.	11.11	999
DAVID FAK-EL 3 MAULOIN AVENUE NORTH EAST MARILAND 2/90/  State 31. Date filed (Month, Day, Year) 32. Registrer's Signeture,	1	_	1	_					, 50	1.101		1 . 4	11	, , ,
State 31. Date filed (Month, Day, Year) 32. Registrer's Signeture	(0								-				110	
Since	4	_		_			-	VE N	ORT	H EAST	とする	-HNO	4190	)
Registrar MAY 1 2 1999 CALLED D. Appendix		3			and the second	Hegistrer's S	igneture	1						

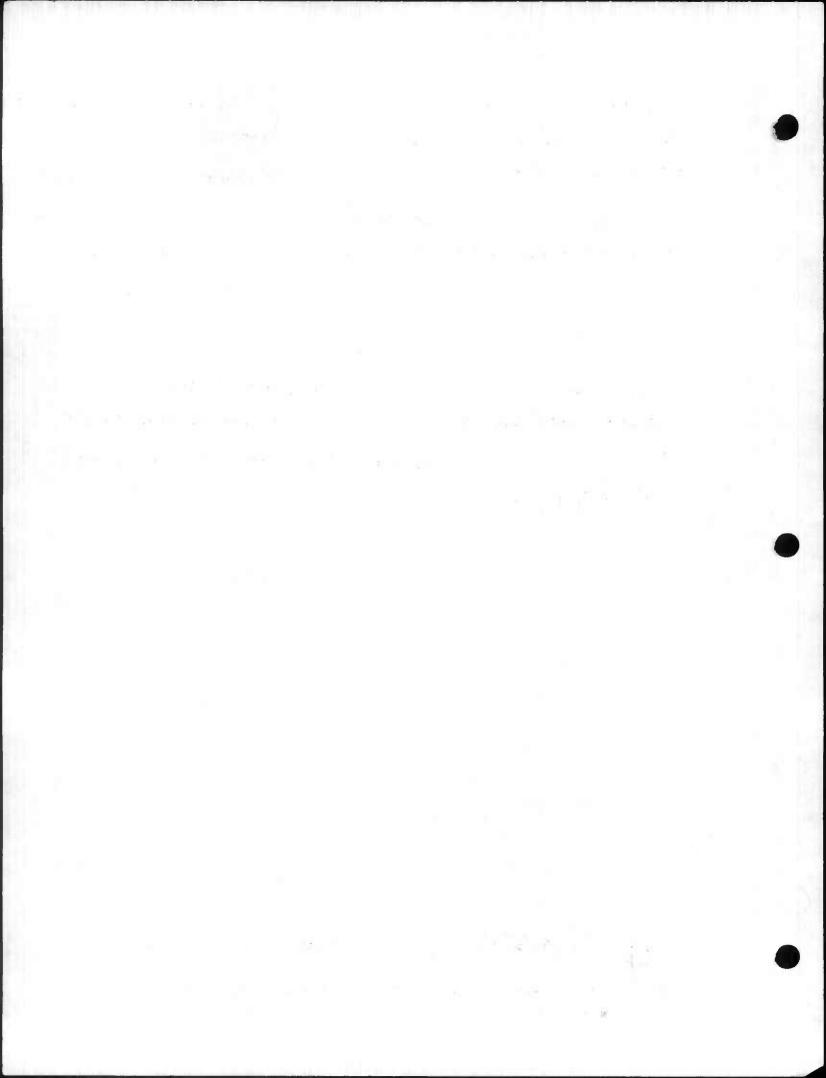
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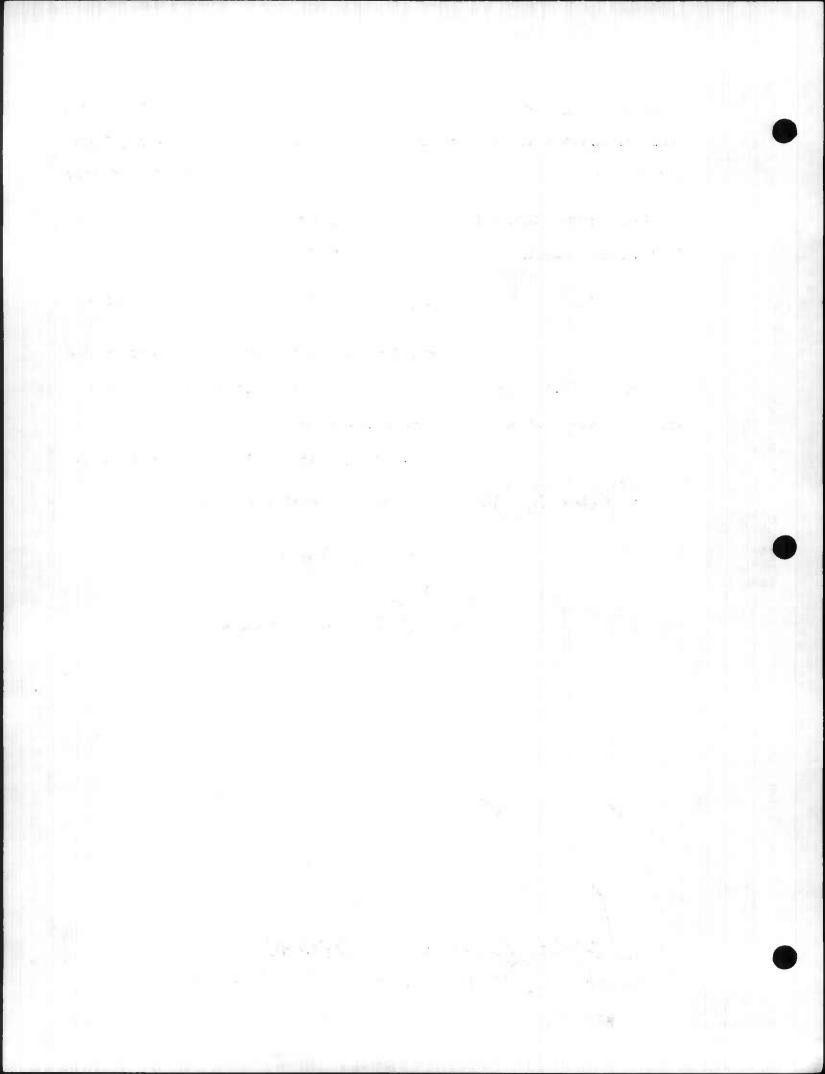
State of Maryland / Department of Health and Mental Hygiene

						Certificate of	f Death	F	leg. No.		
	Physic /Medi		1. Decedent's Neme (First, Middle, La Dorothy Inez					2. Date of Dea		gear	3. Time of Death 11 50 A
	Exami		4a. Facility Neme (If not institution, glv 420 West Dare:			pt. 303	4b. City, Town, or Lo Prince FRe		4c. County Calv		
	Funeral Director		2.0 10 000	6ex 7. Ag □ M 2/□ F 8	ge (In yrs. lest bir 6	thday) If Under 1 Yea Months Dey	s Hours Min.	8. Date of Birth (Month, Dey January	, <sub>Year)</sub> 6 1913	Country	ce (State or Foreign ngton DC
	pue *		Usuei Residence of Decedent  10a. Stata 10b. County		10c. City, Tow	n or Location				104	l. insida City Limits
	Aanyla f sho	ō	Maryland Calvert			Frederick				100.	1 Yes 2 No
	with the I	Director	10e. Street and Number 420 West Dares Be	ach Road A		10f. Zip Code		1	10g. Citizen of V United		
020	a within 72 hours after deeth with the Maryland liene. Than "nature!", or itema 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	11. Merital Stetus  1 Nevar Married 2 Merried  3 Nevar Married 4 Divorced	12. Was Decedent Armed Forces? 1 Yas 2 14 If Yes, Giva Yaar or Datas:	Evar in U,S.	13. Wes Decedent of	Hispanic Origin? (Speban, Mexican, Puerto o Specify:	ecify Yas or No- Rican, etc.)	Blac	e - Amarican ck, White, ato white	
2-0	72 ho	ted	15. Decedant'a Ed (Specify only highest gra	ducation	16a.	Decedant's Usual Occ	upation	ing	16b. Kind of Bu	usiness/Indus	stry
Maryland 21215-0020	within ene.	Completed	Elementery/Secondery (0-12)	College (1-4or		(Give kind of work don life. DO NOT use ratio pmemaker	e during most or work red)	ng	own :	home	
b	be filed tal Hygle d other event, it	BeC	17. Fathar's Name (First, Middla, Last,	)			18. Mothar's Name	(First, Middle,	Maiden Surnam	10)	
/lai		ToE	Harry Shearer				Mary Lou	ise Wil	liamson	•	
	the state of	ľ	19a. Informent's Name/Reletionship ( Patricia I. Wilso			. Melling Address (Stree 06 Daphne C					
Baltimore,	permit. Pages 1 en Department of Heali Important: If item 2 any injury or other once.		20e. Method of Disposition  \$\begin{align*} 2 Donetion 5 Dother (Specification)  200. Method of Disposition  3 Donetion 5 Dother (Specification)		camete	f Disposition (Neme of ry, cremetory or other p r Cemetery 1		Date 9 B	20c. Location -		
Balt	Departi Importu any Inf		21. Signature of Funanci Sarvice Licer	-1			ress of Fecility Rau				
	Physician		23a. Part1. Enter the disaesa, or com shock, or haart failure. List only	pilicetions thet cause one causa on eech ii	ine.	4405 Broomot enter the mode of de	mes Is. Rd ylng, such es cardiec	or respiratory arr	REpubli rest,	C MD 2	20676 pproximate interval Between conset and Death
7	/Medical Examiner		Immediate Cause (Final disaasa or condition resulting in death)	a Card	iac Arhy					mi	nutes
		Je		Coro		consequenca of): cery diseas	e				
	outed nd ransif	Examiner	Sequentially ilst conditions.	b. ————————————————————————————————————		consequence of):					
o,	e exe ian a		Sequentially ilst conditions, if eny, leading to immediata cause. Enter Underlying							į	
Box 68760,	eeth certificate be executed attending physician and for use as the buriel-transit	n/Medical	Ceuse (Disease or injury that initiated events resulting in death) Last	d	Due to (or as a	consequence of):					
	deeth e atte	Icla	Pert II. Other significant conditions of	ontributing to death b	eut not resuiting is	n the underlying cause (	Ilvan in Part i	23b Did to	obacco usa co	ntribute to ti	he cause of death?
, P.O	that the deeth ned by the atter detached for the	by Physician/	Congestive Heart		at not resulting it	in the uniterrying cause (	growth with Gitti.		/ea 2€ No		bly 4 Unknown
Records,	e lew requires hes been sign je 2 should be	Completed b						24a. Wes a perfor		avalla	autopsy findings able prior to oletion of cause ath?
=	T see	Sol						1 🗆 Y	as 2 No	1 🗆 Y	Yes 2□ No
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical exeminer?				28. Place of Deet	h (Check only or	ne)		
of	0 0	2	1 ☐ Yes 2 ☑ No		ant 2 ER/Ou	Itpatient 3LI DOA		ma 5X Rasid	ance 6 Oth	er (Specify)	
	Ing After	ation:	27. Manner of Deeth 1 ☑ Neturel 5 ☐ Pending 2 ☐ Accident invastigetion			Time of 28c. injury M 1	ury et ork? Yes 2 No	28d. Describe h	ow injury occur	red	
Division	al or Attend s after death M Director: A	Certification:	3 Suicide 6 Could not be determined	200. PIGCO OF IN	ury - At home, fe c. <i>(Specify)</i>	erm, street, fectory, offic	6	28f. Location (S City or Tow	itreet end Numb n, State)	er or Rural R	łoute Number,
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	edical (	29a. Certifier 1 Certifying Ph (Check only one) 2 Madical Exam	ysician: To the best niner: On the basis of and menner ste	f examinetion en	o, death occurred et the d/or investigetion, in my	time, dete end place, opinion, death occurr	end due to the d ed at the time, d	cause(s) and ma date and piece,	anner as state and due to th	ed. ne ceuse(s)
	To the To the comple	M	29b. Signeture end titia of certifier	Weight	2	D	nse number 26358		29d. Data aigne May 18		iy, Year)
			30. Neme and Iddress of person who					,			
	Sta	te	John (H. Weigel, 31. Data filed (Month, Dey, Year)		HOSP1Ta. ar's Signature	Road Prin	ce rrederi	CK MD 2	0678		
	010		14 M V 4 A	1000	10000	20					



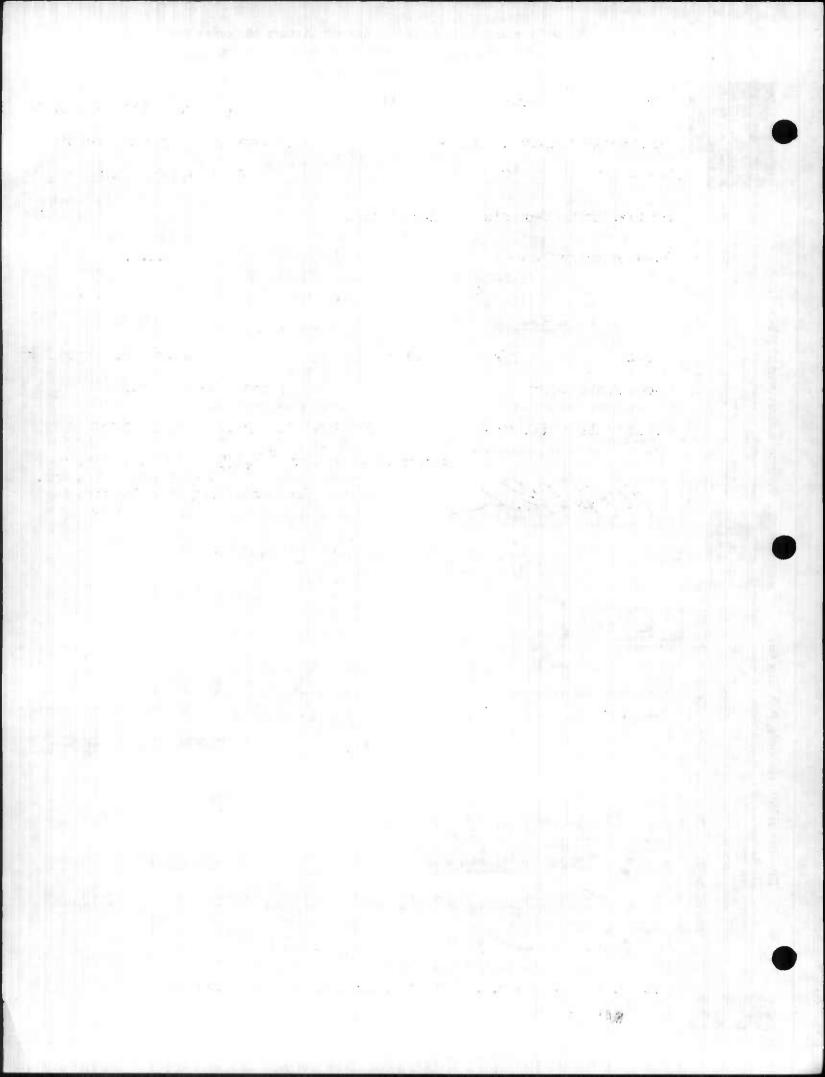
State of Maryland / Department of Health and Mental Hygiene

						Certificate of	of Death		Reg. No.		1641
			1. Decedent's Name (First, Middle, La	st)				2. Date of I	Deeth	Year	3. Time of Deeth
	Physici /Medic	-	JAMES WILL:	IAM HAYES				May		999	9:15 p.m.
1	Examin		4a Facility Neme (If not institution, given				4b. City, Town	n, or Location of Da	ath 4c. Count	y of Death	
			Southern Maryland				Clin				eorge's
	Funeral Director		5. Social Security Number 6. S 412 28 6731 Usual Residence of Decedent	Sex 7. Age (In y		/rs. If Under 1 Y Months Do		Min. 8. Dete of B (Month, I Feb 4	Sirth Dey, Year) , 1924		place (Stete or Foreign ntry) ESSEE
	hand was	1	10e. Stete 10b. County	10c.	City, Town	or Location				T	10d. Inside City Limits
	the Mary 28a-f sh pottred	ector	Maryland Prince	George's		Fo	prestvil	le	10g. Citizen of	What Cou	1 ☐ Yes 2 No
	23a or	Funeral Director	2713 Judith Ave			20	0747		US	SA.	
020	2 should be filed within 72 hours after death with the Maryland and Mental hygiene. Is marked other than "naturel", or flems 23s or 28s-f show rematic event, the Medical Example. must be notified at	þ	11. Mentel Stetus  1 □ Never Married 2√2 Married  3 □ Widowed 4 □ Divorced	12. Wes Decedent Ever in Apped Forces?  1.2 Yes 2 \( \times \) No If Yes, Give Yeer or Dates: 19	n u,s. 42–46	4 TV 6M		n? (Specify Yes or I Puerto Rican, etc.)		ce - Ameri ick, White, by: whi	
5-0	72 ho	eted	15. Decadent's E (Specify only highest gre	ducation ade completed)	18a.	Decedent's Usual Or (Give kind of work de	one during most o	f working	16b. Kind of E	Business/In	idustry
21215-0020	giena. Fr than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	equ	ipment and	d crane				ction
aryland	al Hygie d other vent, E	Be	17. Father's Neme (First, Middle, Last				18. Mother's	s Neme (First, Midd		me)	
yla	should be nd Mental marked o	2	Marion William	4			Ruth	Elizabe		lund	
Mar	2 sh and is m		19e. Informant's Name/Relationship (			Meiling Address (St		or Rural Route Nun	ber, City or Town	, State, Zij	o Code)
	s 1 and 2 should I Haalth and Men tem 27 is marks other treumatic		Mrs. Mary Evelyn 20a. Method of Disposition			ame as # Disposition (Neme of		Date	20c. Location	- City or T	own State
imore,	# O - N		1 X Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Special	Removel from State	cemeter	y, cremetory or other cerans Cen	pleca)	5-17-9			
Balt	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service Lica	R 94_	_	22. Name end A		Home, P.A	Owin	as. N	MD 20736
	THE PERSON		23a. Pert1. Enter the diseese, or com shock, or heert failure. List only	plications that caused the d	eath. Do n					957	Approximate Interval Between
	Physician /Medical Examiner	10	tmmediate Ceuse (Final disease or condition resulting in deeth)	a. Reig	inat	terry	FALL	uo,			Onset and Deeth
	nsit n	듄		b. 05	D					-	
68760,	tificata be executed ng physician and as the burial-transit	edicai Examiner	Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c. CA	uno	onsequence of):	u ()	see	,		
Box 68	certificate nding phy usa as the	5	resulting in deeth) Last	d	oresec	onsequenca of):					
	daath cer a attendir d for usa	Iclar	Pert II. Other significant conditions of	ontributing to death but not	resulting in	the underlying caus	e given In Pert I	23h D	d tobacco use c	on tribute 1	to the cause of death?
P.O.	ras that the dai	/ Physician/		orinioning to double but not	oooning in	and discontinuing dated			□Yes 2□No		
Records,	requii	Completed by							as an autopsy rformed?	an Ci	Vere autopsy findings veileble prior to ompletion of cause I death?
	Tha ata h	Som						10	☐Yes 2☐No	1	☐ Yes 2☐ No
E	slan: artific totor.	Be	25. Was case referred to medical examiner?					of Deeth (Check on	y one)		
5	Physician: r this cartific aral diractor.	2	1 Yes 2 No		ER/Out			ing Home 5 🗆 Re			ify)
Division of Vital	Attending P in death.	ation:	27. Manner of Deeth  1 Maturel 5 Pending  2 Accident investigation	28a. Date of Injury (Month, Dey Year	28b. T	ime of 28c. njury M	Injury et Work? 1 ☐ Yes 2 ☐ No		e how injury occu	irred	
DIVIS	or Atte	Certification:	3 Suicide 6 Could not be determined		t home, fa	rm, street, factory, of	fica		(Street end Nurr Town, Stete)	ber or Ru	rel Route Number,
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this complately filled in by the funeral di	edical C		ysician: To the best of my inner: On the basis of examiner and manner steted.							
	o the	Me	29b. Signature and title of certifier	/		29c. Li	cense number		29d. Dete sign	ed (Month	, Dey, Year)
	->-0		· AN	bloom	3	D	41580	)	5/14	+19	9
,			30. Name and address of person who	completed cause of death (I	tem 23e) (	Type, Print)	41580 Clin	ton,	MD	71	
	Sta Registr	_	31. Date filed (Month, Day, Year) MAY 1 4 1	32. Registrar's SI		B. 1	and				200



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

an	1. Decedent's Name (First, Middle,	Last)					2. Data of De		.	3. Time of Death
al -	Mary	Agnes		Hill			Month May		Yasr 999	6:10PM
er	4a Facility Nama (If not Institution,		- 1			4b. City, Town, or I				
4	Collington Ep  5. Social Sacurity Number		e Care	7 - 64 4 1	dar 1 Year	Mitchell If Under 24 Hrs.				orge's
	579-44-7704 Usual Residence of Decedent	4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	90	Yrs. Month		Hours Min.	8. Date of Bir (Month, Da July 2	4,1908	Wash	ace (State or Foreign y) nington D
-	10a. State 10b. County		10c. City, 7	Town or Location					10	d. Inside City Limits
	Maryland Prince	George's	Mit	chellvil	lle					1 ☐ Yes 2 🕱 No
	10e. Street and Number			10f. 2	Zip Code			10g. Citizen of V	Whet Count	ry?
	10450 Lottsfor	d Road			20716			U.S.A		
	11. Marital Status  1 Never Married 2 Marrie  3 Widowed 4 Divorced	12. Was Decedant E Armed Forces? d 1 Yes 2XN It Yas, Give Year or Dates:	143111		cedent of P pecify Cub 2 1 No	Hispanic Origin? (Span, Mexican, Puerti Specify:	pecify Yas or No Pican, etc.)	Specify	e - America ck, White, e	
	15. Decedent's			16a. Decedent's U	sual Occup	pation		16b. Kind of Bu	usiness/Indi	ustry
-	(Specify only highest Elementary/Secondary (0-12)	grade completed)  College (1-4or 5-		(Give kind of life. DO NOT	work dona	during most of wor.	king			
	12th	N/A	"	Clerk				Andrews	Air I	Force Base
	17. Father's Name (First, Middle, La					18. Mother's Nan		, Meiden Sumem	ne)	
-	John Wesley F	erry				Maud			ısey	
	19a. Informant's Name/Relationshi	p (Type, Print)		19b. Meiling Addre	ess (Street	and Number or Ru	ral Routa Numb	er, City or Town,	Stete, Zip	Code)
-	Father William	Hill (Son)	DOL Die	3300 Mc	prela	nd Place	Bowie M	aryland 20c. Location -	2071	5. State
	20a. Method of Disposition 1 ∑Burial 2 ☐ Cremetion 3		cem	etery, crematory o	or other pla	N D	12,			
	4 ☐ Donation 5 ☐ Other (Spe	**	Resi	urrection		etery	1999	Clintor		
	21. Signature of Funeral Service Li	Consoe /				ess of Facility  Alexandr		e Funera		
1	23a. Part1. Enter the disease, or c	Harle								Approximate
Examiner			Due to for a			Inte	C 103 1		1	
1	Sequentially list conditions,	b		s e consequence d	of):	2,440				18
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated quests)	b	Due to (or e	s e consequence o	of):	2244				
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	Due to (or e	s e consequence o	of):	2,440				
	that intered events resulting in death) Last	b	Due to (or e	s e consequence de se conseque	of): of):			fobacco usa co	ntributa to	the cause of death
	resulting in death) Last Part II. Other significant condition	b	Due to (or as	s e consequence de se conseque	of): of):	ven in Bart I.	23b. Did	tobacco use co Yss 2≝No		the cause of death ably 4 □ Unknow
	resulting in death) Last Part II. Other significant condition	b	Due to (or as	s e consequence of s e consequence of s a consequen	of): of): g cause gi	ven in Bart I.	23b. Did		3 Prob	
	resulting in death) Last Part II. Other significant condition	b	Due to (or as	s e consequence of s e consequence of s a consequen	of): of): g cause gi	ven in Bart I.	23b. Did 1 □ 24a. Was	Yss 2 No	3 Prob	ably 4 Unknown re autopsy tindings ilabla prior to repletion of cause
	Part II. Other significant condition  127 127 277 277 277 275 25. Was case referred to medical	b	Due to (or as	s e consequence of s e consequence of s a consequen	of): of): g cause gi	ven in Bart I.	23b. Did 1 □ 24a. Was perfe	Yes 2 No Yes 2 No	3 Prob	ably 4 Unknown re autopsy tindings ilabla prior to relegion of cause leeth?
	Part II. Other significant condition	b	Due to (or as	s e consequence o	of): of): of): g cause gi	ven in Part I.	23b. Did 1 □ 24a. Was perfe	Yes 2 No Yes 2 No	3 Prob	ably 4 Unknown re autopsy tindings illable prior to relegion of cause leeth?  Yes 2 No
	25. Was case referred to medical examiner?  1 Yes 2 No  27. Menner of Deeth 1 Natural 5 Pending investigal processing investigal processing investigal processing investigal processing investigal processing investigation.	b	Due to (or as	s e consequence o	of):  of):  g cause gi  OA  OII  28c. Inju Wo	ven in Part I.  26. Piace of Dea	23b. Did 1 □ 24a. Was perfet 1 □ ath (Check only) tome 5 □ Resi 28d. Describe	Yes 2 No Yes 2 No Yes 2 No Yes 2 No Yes 2 No Yes 2 No Yes 2 No Yes 2 No Yes 2 No	3 Prob  24b. Wa ava con of d  1   er (Specify	ably 4 Unknown re autopsy tindings iliabla prior to nplelion of cause eeth?  Yes 2 No
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	Part II. Other eignificant condition  25. Was case referred to medical examiner?  1   Yes   2   No  27. Menner of Deeth 1   Natural   investiga investiga   investiga   investiga   determin  29a. Certifier   1   Certifying	b	Due to (or as property of my knowle examination	s e consequence of s e consequence of s e consequence of s a consequen	DOA Office dat the ti	26. Place of Des her: 4 Nursing H my at rk? J Yes 2 No	23b. Did 1	Yes 2 No sen autopsypred?  Yes 2 No one) idence 6 Oth how injury occur (Street and Numb wn, State)  ceuse(s) end me	3 Prob 24b. Wa ava con of d 1   Her (Specify red  anner as sta	ably 4 Unknow re autopsy tindings ilabla prior to npletion of cause leeth?  Yes 2 No  Route Number,
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State of Maryland / Department of Health and Mental Hygiene

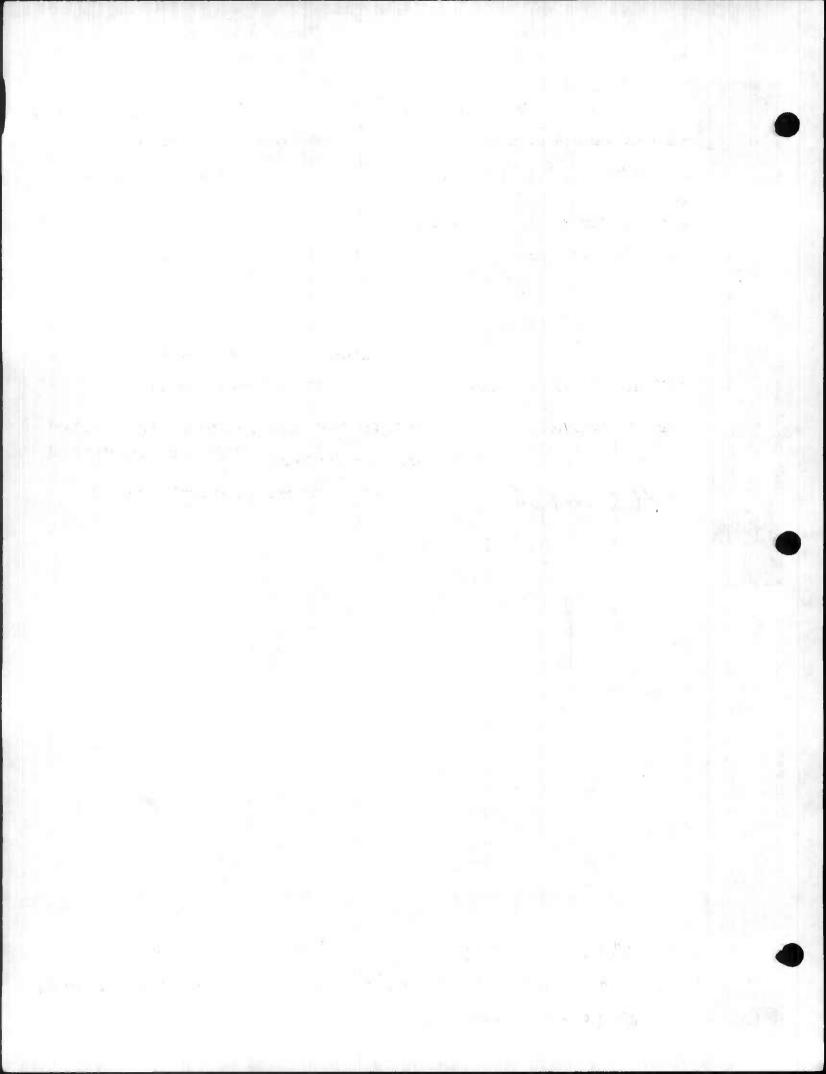
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48 Facility Neme	ir not institution, give	e street end number)			40	. City, Town, or L	ocation of Death	4c. County	or Deetri	
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PA  10e. Street and No.  1524 R  11. Meritel Stetus  1 □ Never Mai		12. Wes Decedent Ev	ver in U,S.	13. Was Dec	edent of His	panic Origin? (Sp., Mexicen, Puerto	ecify Yes or No-	14. Rac	e - American	Indien,
1 Never Mai	rled 2 Merried	Armed Forces? 1 √2 Yes 2 ☐ No If Yes, Give					Hican, etc.)	Bled	ck, White, etc.	
3 ☐ Widowed	4 Divorced	Year or Dates:	1960	1 ☐ Yes	2 No	Specify:		Specify	wi Wi	nite
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(Spe	cify only highest gre	de completed)		(Give kind of v life. DO NOT	vork done du	iring most of work	ding	Salf	Empl	bovo
(Specific Control Cont	ondary (0-12)	College (1-4or 5+	•)	D	b			Barbe		
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20		vens Harv	011							
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Joyce	E. Harve	ey-wife				, Spri	ng Gro	ve, PA	1736	2
20e. Method of Dis			20b. Plece of	Disposition (Nay, cremetory of	leme of r other place	)	Date	20c. Location -	City or Town,	State
	★ Cremetion 3 L 5 Other (Specification)	Removal from State				Servic	e 5/19/9	9 York	, PA	
	unerel Service Licen	<u> </u>	1		and Address		0 0/25/	7 2027	.,	
	1.41	2 1 -				in Funer	al Home	Spring	Grove	Dλ 1
KO	en E.	Herry							GLOVE	, FA I
23e. Pert1. Enter shock, or he	the disease, or comp art feilure. List only	plications that caused to one cause on each line	he deeth. Do i	not enter the m	ode of dying	, such as cardiac	or respiratory ar	rest,	Int	proximate ervel Betwee
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Immediete Ceuse diseese or conditi	(Finel	. Intrav	partition.	1.1	Lancad	1/4460			-2	6 hou
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State of Maryland / Department of Health and Mental Hygiene

		Decedent's Name (First, Middle, La	st)		Cei	rtificat	e or i	Jeath	2. Date of Deef	eg. No. h		3. Time of Death
Physic		Lewis Earl	Isner,	Sr.					Month	Dey /2	Year	1053 PM
/Medi Exami		4a. Fecility Name (If not institution, give					4	b. City, Town, or I		4c. County	of Death	17 5 5 114
Carlotte.		Fallston General	Hospital					Fallstor	1	Harfor	rd	
Funeral Director		5. Social Security Number 6. S 219-34-8934 Usual Residence of Decedent	Sex 7. A	ige (In yrs.	last birthday) Yrs.	If Under Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 31	Year) , 1941	9. Birthp Coun Mary	piace (State or Foreignty) Land
death with the Maryland ms 23a or 28a-f show ground be notified at		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					1	0d. Inside City Limit
th with the Marylar 23a or 28a-f show	cto	Maryland Harford		Abi	ngdon							1 Yes 2 N
15 to 15	Dire	10e. Street and Number				10f. Zip	Code		11	Og. Citizen of V	Vhat Cour	ntry?
ath w	Ta.	207 L. Oak Leaf C	ircle			21	L009			USA		
ours after el', or its Examine	by Funeral Directo	11. Maritel Stetus  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1. Yes 2 ☐ if Yes, Give Year or Dates:	? No		Was Deced f Yes, sped 1 ☐ Yes		spenic Origin? (S) n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	Blac	e - Americ ck, White, :: Whi	
2 should be filed within 72 h and Mental Hygiene. Is marked other than "natul aumatic event, me Medical	. 2	15. Decedent's Ec (Specify only highest gre Elementary/Secondary (0-12)	ducation de completed)	bleted)  16a. Decedent's Usual C (Give kind of work of life. DO NOT use i			rk done d se retired	etion furing most of wor )	king	16b. Kind of Business/Industry		
Hygi Hygi	Ö	17. Father's Name (First, Middle, Last)			Auv	er crs	эшч	18. Mother's Nan	ne (First, Middle, N	Newspap		
id be ental ked o	To Be	William Jenni		ner			1	Ellen		Daniels		
should nd Men marke umatic	-	19a. Informant's Name/Relationship (			19b. Mailin	ng Address	(Street		ral Route Number,			Code)
1 and 2 Health a em 27 le		Terri L. Isner/w	ife						Abingd			
permit. Peges 1 and 2 a Department of Health ar Important: If Item 27 is any Injury or other trau once.		20a. Method of Disposition		20b. F	Place of Dispo	sition (Ner	ne of other plac		Dete 2	20c. Location -	City or To	wn, State
Peges nent of ant: If its		1 ∑Buriei 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		9				Spesuti	5/17/99	Perryma	an, M	aryland
permit. Pege Department of Important: If any Injury or once.		21. Signeture of Funeral Service Licen	see		22	. Name en	d Addres	s of Facility				
80558		23a. Part . Einer the diseese, or com shock, or heart feilure. List only	le		H	oward	k.	McComas	III Fune	ral Hor	ne, P	.A.
/Medical Examiner	iner	Immediate Cause (Final disease or condition resulting in death)	. CANO	Due to to	V OPA 1 or as a conseq	uence of):	205					
eath certificate be executed effending physician and for use as the buriel-transit	Aedicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c. PNEWM	Due to (o	r es e conseq	uence of):						
certif nding use a		,	d									
death e ette d for	icia	Part II. Other significant conditions co	ontribution to death t	out not ree	ulting lo the un	dodvina o	augo dina	on in Part I	22h Bld tol		staller to to	the server of deat
es that the de igned by the be deteched	by Physician/	Tarri. Other significant conditions of	outripoting to death t	out not rest	uting in the un	idenying c	ause give	in in Part I.		s 2 No		the cause of deat
ew requir	Completed b								24a. Was ar perform	autopsy ned?	cor	ore autopsy findings eilable prior fo appletion of cause death?
	S								1 ☐ Ye	s 2 110	1 🗆	Yes 2□ No
Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Linenitali e				Tou		th (Check only one	)		
this aldi	. To	1 ☐ Yes 2 ☐ No  27. Menner of Death	Hospitei:		ER/Outpatient			4 LI Nursing H	ome 5 Reside			1)
D P P	ion	1 Anatural 5 Pending	28a. Date of fnju (Month, De	y Year)	Injury	M	8c. fnjury Work		28d. Describe ho	w injury occurr	ea	
Ta K	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		jury - At ho tc. <i>(Specif</i> )	At home, farm, street, factory, office			65 2 140	28f. Location (Street and Number or Rural Route City or Town, State)			
oute Hospital of Atta within 24 hours after de To the Funeral Direct completely filled in by the	edicai C	29a. Certifier (Check only one) 1 Cartifying Phy	/sician: To the best finer: On the basis o and menner st	if examinat	wledge, death ion and/or inv	occurred a	at the tim	e, date and place, inion, death occur	and due to the ca red at the time, da	use(s) and ma te and place, a	nner as st	ated. the cause(s)
within 2 To the comple	Me	29b. Signature and title of certifier				290	License	number	29	d. Date signed	(Month, I	Day, Year)
		*/\\\\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	_	UND			109	15921		MAN	14	1996
				VV-7						177	1 4	((/)
121	+	30. Name and eddress of person who d	completed cause of c	death (Item	23a) (Type. F	Print)					-!-	
M		30. Name and eddress of person who of year Mah mod U, 31. Date filed (Month, Dey, Year)	mpleted cause of c	FC /	Vorth	AVE	, 5	Suite "	+24 B	SEI Ain	M	W 2101

DHMH 16 Rev 6/95

ISNER LEWIS EANIE



	4	Decadent's Ma	a /Fires & Aidall-	l and			ertifica	le UI	Dealli	2. Dete of 0	Reg. No.			2 Time of the
ician dical		Decedent'a Nam	e (First, Middle) NNIE	MAE	JONES					Month MAY	Day	999	Year	3. Time 1 th  12:15 pm
niner	4.0	Facility Name (I	If not Institution	, give street er	nd number)				4b. City, Town, o	r Location of De	eth 4c. Co	ounty of	f Death	
Ī		Social Security N	lumber	S HOSP	JE .	rs. lest birthde	Months	or 1 Year Days	CHEVE If Under 24 Hr Hours Mi	s. 8. Dete of E (Month,	3irth De <i>y, Yeer)</i>	9		ce (Stete or Foreign
		577-56-5 suel Residence of			58					MARCH	22, 19	941_	SOUTH	H CAROLIN
	10	De. State	10b. County		10c.	City, Town or	Location						10d.	. Inside City Limits
ctor	M	ARYLAND	PRINCE	E GEORG	E'S	GREENB	ELT							1 ☐ Yes 2 ☐ No
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State of Maryland / Department of Health and Mental Hygiene

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Examiner		(If not institution, gi		mber)						cation of Death	4c. County	of Death	)
4		eneagles						Silver				gome	ry
Funeral Director	5. Sociel Security 154 –16 – 37		Sex 1 □ M 2 XF	7. Age (In yr. 7.7	s. last birthday, Yrs.	Months	1 Year Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Birth (Month, Day Nov. 30	1921	Cou	nplaca (State or Fo untry) Jersey
9	Usuel Residence												
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The Hospital or Attending Physician: The law requires that the deeth certificate be executed in 24 hours after death.  The Funeral Director: After this certificate has been signed by the attending physician and plately filled in by the funeral director, page 2 should be detached for use as the bunial-transit edical Certification: To Be Completed by Physician/Medical Examiner	diseasa or condition resulting in death)  Sequentielly list of it any, leeding to it causa. Entar Und Cause (Disease of the tinitiated even resulting in death)  Pert II. Other sign  25. Wes case reference or causal in the caus	onditions, immediate lerlying in Injury is Last  Micant conditions  To Pending invastigatic 6 Could not determined.	Hospitel: 1   1   1   28a. Detection on the best of the miner: On the base of the miner: On the	Due to  Due to	(or as a consection of the con	quence of):  Quenc	A Other Bc. Injury of the tire in my o	26. Plece of the results of the resu	of Death sing Hon 2	23b. Did to 1 24a. Was a perior of the control of t	obacco use cores 2 No ne) lence 6 Otto now injury occurs of the core of the co	3 Pr 24b. V 3 C C 1 1 her (Spectred)	Ners autopsy findin trailable prior to completion of caused death?  Yes 2 No city)
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from the sold will

MAY 1 1 1995

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 05 **Physician** ANNIE E. JOHNSON 99 2:00 am /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death Examiner PRINCE GEORGE'S HOSPITAL CENTER CHEVERLY PRINCE GEORGE'S If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthpiece (State or Foreign Country) **Funeral** 1□ M 21 F Yrs. November 24,1913 Upper Marlboro, MD 220-16-4809 85 Director Usual Residenca of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28a-f ahow traumetic event, the Madical Examiner must be notified at 1 No Yes 2 □ No Directo Maryland Prince George's Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1925 Bellehaven Drive, #104 U.S.A.

14. Raca - American Indian, 20785 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after to Depermant of Health and Mentel Hygiene. I important: If item 27 is merked other than "natural", or item any injury or other traumetic event. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ZINo Specify: þ Black. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Cook 7th Private 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Edward Johnson Sarah Jane Evans 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reietlonship (Type, Print) Jeanette Johnson/Daughter 1925 Belleraven Drive, #104, Landover, Maryland 20785 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other placa) Date 05/18 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removel from State Moses Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 1999 Lothian, Maryland 22. Name and Address of Facility 21. Signature of Funerel Service Licenses J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert feiture. List only one cause on each line. Approximete Interval Between Onset end Deeth Physician Immediate Cause (Final disease or condition resulting in deeth) /Medicai ULMONARY EDEMA **Examiner** CUTE RENAC Examiner physician and the burial-tran Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last SEPSIS Physician/Medical Due to (or as a consequence of). METASTATIC UTERINE CARCINOMA esn signed by the a d be datached t 23b. Did tobacco use contribute to the cause of deeth? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evallable prior to 24e. Wes an eutopsy performed? Completed completion of cause of death? 105 1 ☐ Yes 2 No 1 ☐ Yes 2 € No 25. Was case referred to medical exeminer? Be 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 28e. Dete of Injury (Month, Day Year) ie Hospital or Attending P 24 hours after deeth. e Funeral Director: After ti Certification: 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homlcide 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and pleca, and due to the cause(s) and manner as stated. Medical completaly 2 Medical Examinar: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, dete and placa, and due to the cause(s) and manner stated. To the To the To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number largan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LIPISHREE NAYAK 6501 LANDOVER ROAD, CHEVERLY 20785 32. Registrar's Signature 31. Date filed (Month, Day, Year) MAY 1 4 1999

**DHMH 16 Rev 6/95** 

Registrar

with the Maryland

death

Maryland 21215-0020

Baltimore.

PO

Division of Vital

State of Maryland / Department of Health and Mental Hygiene

							Ce	ertificat	e of	Death		R	eg. No.	2	1000
			1. Decedent's Name (First, I	liddle, La	st)							2. Date of Deat Month	h Dey	Year	3. Time of Death
	Physicia /Medic		John Kenneth	Jam	es							MAY 14,		T Gal	1319
	Examin		4a Facility Name (If not insti	tution, giv	e street and num	iber)				4b. City, To	wn, or Lo	cation of Death	4c. County	of Death	
			Sacred Heart I							Cumbe				egany	•
	Funeral Director		5. Social Security Number 214-10-5078		ex ØM 2□F	7. Age (In yrs 82	. last birthda Yrs.	Months	1 Year Days		24 Hrs. Min,	8. Date of Birth (Month, Day, 25-Aug-		9. Birthp Cour	
	Pu B	1	Usual Residence of Deceder 10a. State 10b. Co			10c. C	ity, Town or	Location		_		-		1	10d. Inside City Limits
	Se-f shoot	Director	Maryland	Alleg	any	Fro	stburg								1 Yes 2 No
	23a or 2			0 Hon	eysuckle l	.ane		10f. Zip	2153	32-		1	0g. Citizen of V		itry?
Maryland 21215-0020	urs .	by Funeral	11. Merital Status  1 Never Married 2 3 Widowed 4 Divo	Merried	12. Wes Dece Armed For 1 Yes If Yes, Give Yeer or De	ces? 2 No	U,S. 13	Was Dece If Yes, spe	cify Cub	an, Mexicar	n, Puerto	ecify Yes or No- Rican, etc.)	Blac	e - Americ ck, White, White	
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and	2 2 2 2	Be	17. Father's Name (First, Mic									(First, Middle, I	Aaiden Sumeir	10)	
Z		2	Joseph A. Jam						10.		rie Po			0 7.	0.41
Ma			19a. Informant's Name/Rela		5-6-2		19b. Me	iling Address	(Stree	t and Numb	_	Il Route Number			
	1 and 1 Health arm 27 I	-	Helen E. James 20a. Method of Disposition		Wife	20b.	Place of Dis	oneysuc		one	hr	Ostburg Date	MON 20c. Location -	/land	21532-
Baltimore,	2722		1 Burial 2 ☐ Creme				cemetery, cr	emetory or o	ther ple	(ce)					
를		-	4 Donation 5 Other		()	Fros	tburg Me	morial Po 22, Name ar		on of Engiti		May-99	rostburg	Mary	rland
Ba	Depart Import any in		Vohn	K	Du.	ect	200					ost Ave., F	rostburg.	MD 2	21532
			234 Bent1. Enter the diseas	e, or com	plications that ca	used the dea	ath. Do not e	nter the mod	le of dyi	ing, such as	cardiac c	or respiratory arm	est,	1	Approximete Interval Between
	Physician							_						1	Onset and Deeth
7	/Medical Examiner		Immediate Cause (Final disease or condition		. 5	eve	ve	Yn	eu.	mon	ia				30 days
в			resulting in death)			Due to	(or as a cons	equence of):							-
	D #	line			b									1	
0,	difficate be executed to physician and es the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury			Due to	or as a cons	equence of):							
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P.0.	that the de- ned by the e- detached f	/ Phys	Severe	OP	D		dome		Pv	ven in Perti	u) -	1 1 X			o the cause of death?
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ta	yalcien: The la is certificate ha director, page		25. Wes case referred to me	dical	0(00		me	lin.	>	26. Place	e of Deeth	(Check only on			
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10	E 5 5		27. Mannet of Death		28a. Date o	·	28b. Time		8c. Inju		1	28d. Describe ho			
0	Attending Phir death.	ate	1 DrNetural 5 □ Pe 2 □ Accident in	nding restigation		i, Day (Bar)	Injury	м		Yes 2	No				
Division	or At offer of Sirect in by	Certification:	3 Suicide 6 Code 4 Homicide	uld not be termined	28e. Place o	of Injury - At I g, etc. (Spec	home, farm, s	street, fector	, office			28f. Location (Si City or Town		er or Rure	al Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical C	29s. Certifier 1 Cert (Check only one) 2 Med	ifying Phi Ical Exam	liner: On the bar	sis of examin	owledge, dea ation and/or	th occurred investigetion	at the ti	me, date an opinion, dea	d place, a	and due to the co	ause(s) and ma ate and place,	inner as s	itated. o the cause(s)
	o the o the omply	¥ ·	29b. Signature and title of ce	rtifier	and mann	C. Stated.		29	. Licen:	se number		2	9d. Date signe	d (Month,	Day, Year)
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John Kenneth James

Sacred Heart Hospilal

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25-Aug-16 Maryland

Allegany

214-10-5078

Maryland

Joseph A. James

Helen E. James

Allegany

Frostburg

100 Honeysuckle Lane

Apt. 111

21532-

U.S.A.

While

Accountant

Bothstas Lab and tem

Marie Powell

Cumberland

100 Haneysuckle Lane Frostburg Maryland 21532-

Frostburg Membraal Park 17-May-99 Frostburg, Maryland

Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Day Year **Physician** JENKIMS 09:25 10H0 WESLEY 1999 11 MAY /Medical 4a Facility Nama (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** H D F If Under 24 Hrs. 57 ALLIANCE HARFOND 553 If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) Date of Birth (Month, Dey, Year) Birthplaca (State or Foreign Country) **Funeral** XXM 2 F Months Days Director MD 213-26-1829 66 March 1,1933 Usuai Residenca of Decedent the Maryland 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28a-f show the Medical Examiner must be notified at Yes 2 No Directo Harford Havre de Grace 10e. Streei end Number 10f. Zip Code 10g. Citizen of What Country? with 553 Alliance Street 21078 USA permit. Pages 1 and 2 should be filed within 72 hours after deeth Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "netural", or flems 23s any injury or other traumatic avens. Funerai 12. Was Decedent Ever In U.S. Amped Forces? \*EPYes 2 □ No 1953 If Yes, Give Yeer or Dates: 1955 Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian. Black, White, etc. Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ◯ No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) A.P.G. Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be John Jenkins, Sr. Ella Bradley 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. informent's Name/Relationship (Type, Print) 553 Alliance Street, Havre de Grace, MD. 21078 Margaret Taylor 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stata XX Buriel 2 Cremation 3 Ramoval from State James Cemetery 5/15/99 Havre de Grace, MD 4 Donetion 5 Other (Specify) St. 22. Name and Address of Facility
Beard Funeral Home 21. Signature of Funeral Service Licenses 552 Lweis Street, Havre de Grace, MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical immediate Causa (Final HEART FAIWALE CONGESTIVE diseese or condition resulting in deeth) Examiner Due to (or as e consequence of): Examiner law requires that the death certificate be executed Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest physician and the bunal-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical Dua to (or as a consequence of) attending p as signed by the al Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Dld tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yee 2 No CUA by 24b. Were autopsy findings available prior to 24e. Was an eutopsy Completed completion of ceuse of death? pege 2 hes 1 Yes 210 No 1 Yes 2 No certificate Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certification. director, Be 25. Was case referred to medicel 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Reasidence 6 Other (Specify) 2 1 Yes 2 No 1 inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Deeth 28a. Dete of fnjury (Month, Dey Year) 28c. fnjury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 Yes 2 No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner es stated.

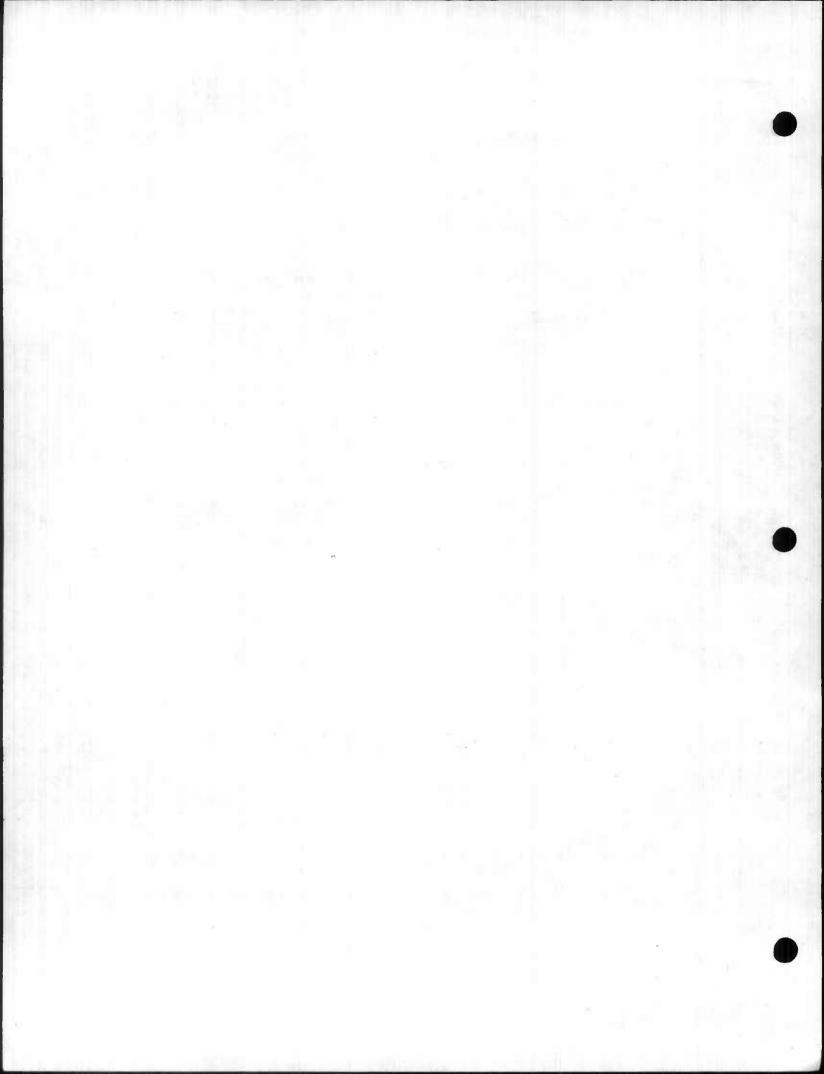
2 Aledical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred et the time, dete and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai 29d. Date signed (Month, Dey, Year) 29b. Signatora end titla of certifier 29c. License number 1999 DM E OCME 30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print) 31. Date filed (Month, Dey, Year) MD 21014 AVE BELAN MO 218 FULFONS 32. Degistrar's Signature State MAY 1 4 1999 empra Registrar

	Decedent's Name (First, Middle, Last)			Certificati	e of Death	2. Date of Dea	Reg. No.		3. Time of Death
ysician						Month May	Day 1.0	Year	O . / EDM
Medical aminer	Pearl A. Kerr  4e Facility Name (If not institution, gives	street end number)	1		4b. City, Town,	or Location of Deeth			9:45PM
u	Asbury Methodist	Home			Gaithers	sburg	Montgo	omery	
eral ctor	5. Social Security Number 6. Security 1		ge (In yrs. lest 92	birthdey) If Under Months		lrs. 8. Date of Birt (Month, Day January	y, Year)	Countr	ica (Stete or Foreign y) Land
=	Usual Residence of Decedent  10e. Stete 10b. County		10c. City, T	own or Location				10	d. Inside City Limits
tor	Maryland Montgome	rv	Gaith	ersburg					1 ☐ Yes 2 ☑ No
Director	10e. Street and Number			10f. Zip	Code		10g. Citizen of V	What Countr	γ?
rair	401 Russell Avenue		-		877		United		
edcal Examiner must be notified all leted by Funeral Director		12. Was Decedent Armed Forces? 1 ☐ Yes 2X	,	13. Was Deced	ent of Hispanic Origin? ify Cuban, Mexican, Pu	(Specify Yes or No- verto Rican, etc.)	Biad	e - America ck, White, et	
by F	1 Never Merried 2 Married  3 Widowed 4 Divorced	It Yes, Give Yeer or Dates:	INO	1□ Yes	No Specify:		Specify	·: W	hite
ted ted	15. Decedent's Edu		1	6a. Decedent's Usua	l Occupation	undina	16b. Kind of B		
	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or	5+)		k done during most of e retired)	WOINING			
	10			Clerk Typ		Name (First, Middle,	D.C. (		ment
Be	17. Father's Name (First, Middle, Last)								
To	John William Padd  19a. Informant's Name/Relationship (Ty.)			19b. Maiiing Address	(Street and Number or	Priscill			Code)
trau	Willaim H. Henson				Valley Dr:		•		
othe	20a. Method of Disposition		COM	a of Disposition (Ner etery, cremetory or o	ne of	Dete	20c, Location -		
iry or	1 Buriei 2 ☐ Cremation 3 ☐ R 4 ☐ Donetion 5 ☐ Other (Specify)	emoval from State		Lincoln		5-8-99 E	Brentwoo	d, Ma	ryland
any injury ance.	21. Signature of Funeral Service Ligense	M /		22. Name an	d Address of Fecility	ral Home			
E 8	Vin S	Jolla	sou	3 1	densburg R		wood, M	ary1a:	nd 20722
:lan	23a. Part T. Enter the disease, or complishock, or heart feilure. List only or	cations thet cause to cause on each i	d the deeth. I	Do not enter the mod	e of dying, such as care	dlac or respiratory en	rrest,	. 1	Approximete Intervai Between Onset and Death
ical	Immediate Cause (Final disease or condition		electr	olyte in	halance				hours
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buriel-transit	Sequentially list conditions, if any, leading to immediate			s a consequenca of):				i	
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be deteched for use as the by Physician/Medica		l							
ched	Part II. Other significant conditions con	tributing to death b	out not resulting	ng in the underlying c	ause given in Pert I.				the cause of death
y Ph	Previous colon	carcho	ma,	anenta	, gastro.		Yes 2DK,No	3 Prob	ably 4 Unknow
page 2 should by	esophageal net					24a. Wes	an autopsy ormed?	ave	re autopsy findings ilable prior to apietion of cause eath?
om						10	Yes 2 No	10	Yes 2□ No
Be C	25. Was case reterred to medical examiner?				26. Plece of	Death (Check only o	one)		
To F	1 Yes 2 No	lospitai: 1 🗌 Inpati	ent 2 ER	VOutpatient 3□ DC		ng Home 5 ☐ Resid			)
completely filled in by the funeral director, page 2  Medical Certification: To Be Comp	27. Manner of Deeth  1 Neturei 5 Pending 2 Accident investigation	28a. Date of Inju (Month, De	by Year) 28	Bb. Time of 2 Injury M	8c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	how injury occur	red	
led in by the funera Certification:	3 Suicide 6 Could not be determined	28e. Place of In building, e	jury - At home tc. <i>(Specify)</i>	, ferm, street, factory	, offica	28f. Location ( City or Tou	Street end Numb wn, Stete)	ber or Rurai	Route Number,
edical			t examinetion		et the time, date and pl In my oplnion, deeth o				
· 🖁	29b. Signeture and title of certifier	0.4	,		License number		29d. Date aigne		
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Med	30. Name and address of person who co Priscilla Callakar	mpleted cause of	deeth (item 2		55811 Ave	6aithers			

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State of Maryland / Department of Health and Mental Hygiene

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Physician	_	MERLE EI	WARD K	ENNELL						Month 5	Day	13 Yang 9	21:00
/Medica Examine		4a Facility Neme (If no SACRED I			,	8 -			4b. City, Town, or CUMBERLA			County of Death	
Funeral Director		5. Social Security Num 208 03 937	78	Sex 1 M 2 □ F	7. Age (	n yrs. last bir	thday) If Under 1 Yrs. Months	Yeer			irth 1920	9. Birth PENN	place (State or Foreig ntrv) SYLVANIA
yland		Usual Residence of De 10a. Stete 1	ocedent Ob. County		1	Dc. City, Tow	n or Location						10d. Inside City Limit
Mar of at	ğ	MARYLAND A	LLEGAN	Y		FROSTE	BURG					31	1 X Yes 2 N
th the	S S	10a. Street and Number	er				10f. Zip C	ode			10g. Citize	en of What Cou	ntry?
23a	la l	171 S. WA	TER ST	REET			21.	532	2		U.	S.	
urs effer death with the Manylar all, or Herna 23a or 28a-f show marricer must be notified at	by Funeral Director	11. Meritel Stetus  1 Never Merried  3 Widowed 4		12. Was Dec Armed F 1  Yes If Yes, G Yeer or I	orces? 2 🗓 No	er in U,S.	13. Was Deceder If Yes, specify 1 Yes 25		Hispanic Origin? (Span, Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)		14. Rece - American Indian, Black, White, etc. Specify: WHITE	
n 72 ho	Completed	(Specify Elementery/Secondo		rade completed,	(1-4or 5+)		Decedent's Usual (Give kind of work life. DO NOT use	done	during most of wo ad)			d of Business/Ir	edustry
filed with Hygiene. Wher than		17. Father's Name (Fir	st, Middle, Las	()		111	CACTOR IN	ATI		me (First, Middle		R TRANS	PURI
Saby C	o Be	HOBART K							ERMA L	EPLEY			
2 should and Men la marke aumatic		19e. Informent's Name	Alationship	(Type, Print)		19b	. Mailing Address (	Stree	t end Number or R	lural Route Num	ber, City or	Town, State, Zi	o Code)
elith celth		ANNA KENN	IELL /	WIFE		17	1 S. WATI	ER	ST., FRO	STBURG,	MD 2	1532	
Peges 1 and the ment of He ment: If Nem		20a. Method of Dispos 1	cremetion 3 (		State	20b. Pieca of cemere:	f Disposition (Neme ry, cremetory or oth MEMORIA)		1	7/99		ation - City or T	
permit. Peg Department Important: eny injury c		21. Signeture of Funer	al Service Lice	ensee			22. Name end SOWERS 1	Addro FUN		E, P.A.			
	cal Examiner	Immediate Cause (Findisease or condition resulting in deeth)  Sequentially list condition resulting in deeth)  Sequentially list condition if any, leading to immediate. Enter Underlyi Cause (Disease or injutat intileted events resulting in deeth) Las	cions, odiate ng	b		e to (or as a	consequence of): consequenca of):	_/				9	WA   3
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has been sign ge 2 should be	Completed b	COK	ONF	PRY	4	RTE	RT I	)	ISEASE		s en autops formed?	a	Vere autopsy findings vailable prior to ompletion of cause i death?
certificate he rector, page												No 1	Yes 2 No
After this funeral di	0	2 Accident	Pending investigation	28a. Date (Mor	nth, Dey Y	ear) I	Fima of 28c njury M	c. Inju Wo	her: 4 Nursing I	Home 5 Res	sidence 6 how injury	occurred	,
		4 ☐ Homicide	determined	build	ding, etc. (	Specify)	m, street, factory, o		me date and all	City or To	own, Stete)		ral Route Number,
Hospita 24 hours Funeral letely filled	edical	(Check only 2 one)	Medical Exa	miner: On the b	e best of n pasis of ex nner state	amination an	dor investigation, in	n my	opinion, death occ	urred et the time	, date end	placa, and due	to the cause(s)
4	Me	29b. Signature and title	of certifier	Myt	ing	Pu	m 29c. 1	Licen	se number	-/	29d. Date	signed (Month	, Dey, Year)
19/12 +4 8	A A	30. Name and address	of purson who	completed cau	ise of deat	h (Item 23a)		~ ^		thure	may/	7,1999	-5 7
State	a	31. Date filed (Month)	pay, Year)	32. F	Registrer's	Signature	day A	10	- , Fros	Dure	3///	~ X/3	27



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Desth Day **Physician** 5 50 PM 1999 ELSIE KAVANAGH MARY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street and number) Examiner Fallston Fallston General Hospital Harford If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months Deys 1□M 2▼F 95 212-18-4473 Director 12/6/1903 Washington, DC Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Haalth and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-f show may fujury or other traumatic event, the Mod call Examples must be notified at once. 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Harford Forest Hill MD. 10e. Street and Number 10f. Zlp Code 10g. Citizen of Whet Country? U.S.A. 1227 Walters Mill Road 21050 Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No if Yes, Give Yeer or Detes: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 ☐ Divorced Caucasian Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Nurse Nursing 10 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be William Washington Acton Ella S. Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark A. Dardozzi/Grandson same as #10 20b. Placa of Disposition (Name of cametery, crematory or other placa) 20e. Method of Disposition 20c. Location - City or Town, State 5/11 1 ☐ Burial 2 II Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 1999 Carroll Cremation Hampstead, Maryland 21, Signature of Funeral Service License 22. Name and Address of Facility E.G. Kurtz & Son Funeral Home, P.A. Jarrettsville, Maryland 23a. Part1. Enter the disease, or complications that cause shock, or heart feilure. List only one ceuse on each Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) · ACUTE MYOCARDIAL INFARCTION Examiner Physician/Medical Examiner ARTER" DRONARY attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be axecuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequenca of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? Kavanagh. 1766 1 Yss 2 No 3 Probably 4 Unknown HIP FRACTURE by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en autopsy performed? Completed certificata has b 1 ☐ Yes 2 FNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 9 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 27. Manner of Death 28b. Time of 28c. injury at Work? Certification: 1 Naturel 5 Pending Investigation 4 hours after death. Funeral Director: Aft tely filled in by the fur 1 TYes 2 □ No 2 Accident the Funeral Director filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi edicai (Check only one) 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name and address of person wife completed cause of death (Item 23e) (Type, Print) MD 21014 4BHYHNICAR BEL AIR 2 NORTH AVE State Registrar

1 11111

the Maryland

filed within 72 hours after

21215-0020

Baltimore, Maryland

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Year **Physician** Krell 0633 AM David Charles 1999 MAY 12, /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CALVERT MEMORIAL HOSPITAL PRINCE FREDERICK CALVERT 7. Age (In yrs. last birthday) ff Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 7, 1963 9. Birthplaca (State or Foreign Country) Washington DC 5. Sociel Security Number **Funeral ₩** 2□ F Months Days Hours 217-88-8377 Yrs. Director Usuel Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f ahow a notified at St. Leonard 1 ☐ Yes AND No Director Maryland Calvert 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number r hema 23a or 2 anar mast be n U.S.A. 6755 Ben Creek Road 20685 Funeral 12. Wes Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indien, Black, White, etc. 11. Merital Status "naturel", or iter 1 Never Merried 2 Merried 1 Yas 2 No If Yes, Give Yeer or Detas: White 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 Divorced Hygiane. other than "nature ent, the Medical Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Scrap Metal Industry Assistant Manager 11th N/A marked other 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental Hant: If item 27 is marked oth jury or other traumatic even Holt Conrad Krell Lena 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9000 Townsend Lane Clinton, Maryland 20735 Leona M. Krell (Mother) 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Steta Mary 1970 1 Burial 2 Cremetion 3 Removat from Stata permit. Page Department of Important: If any Injury or pages. 1999 4 Donetion 3 □ Othar (Specify) Resurrection Cemetery Clinton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735 De Part 1. Enter the disease, or complications thet eaused tha deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Betw Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Multiple injunies Examiner Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or es a consequence of) 88 080 signed by the atte Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No certificata 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospitel: 1 ☐ Inpatient 3☐ ER/Outpatient 3☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this funeral 27. Manner of Death 28a. Dete of tnjury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural Injury death. 1 Yes 2 No 2 Accident 3 ☐ Suicide 5-12-99 0545 motor vehicle accident after death Director: 28t. Location (Street and Number or Rural Route Number, City or Town, State) Calvert beach Garyson 6 Could not be 28e. Pleca of Injury - At home, ferm, street, fectory, office bullding, etc. (Specify) AQ U 4 Homicide Street • Funeral Calvert County, Maryland 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and menner es stated.
| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29e. Certifier within 24 hor To the Fune completely fi Medicai (Check only one) 29b. Signature and title of certifiar 29c. License number 29d. Date signed (Month, Day, Year) MAY 12 1999 O.C.M.E. 30. Name and address of person who completed cause of death (Item 25a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 Radentz Stephen 5, 32. Registrar's Signetura

**DHMH 16 Rav 6/95** 

State

Registrar

31. Date filed (Month, Day, Year)

14

rene

Hospital or Attending Physician: The law requires that the death certificate be executed

Box 68760.

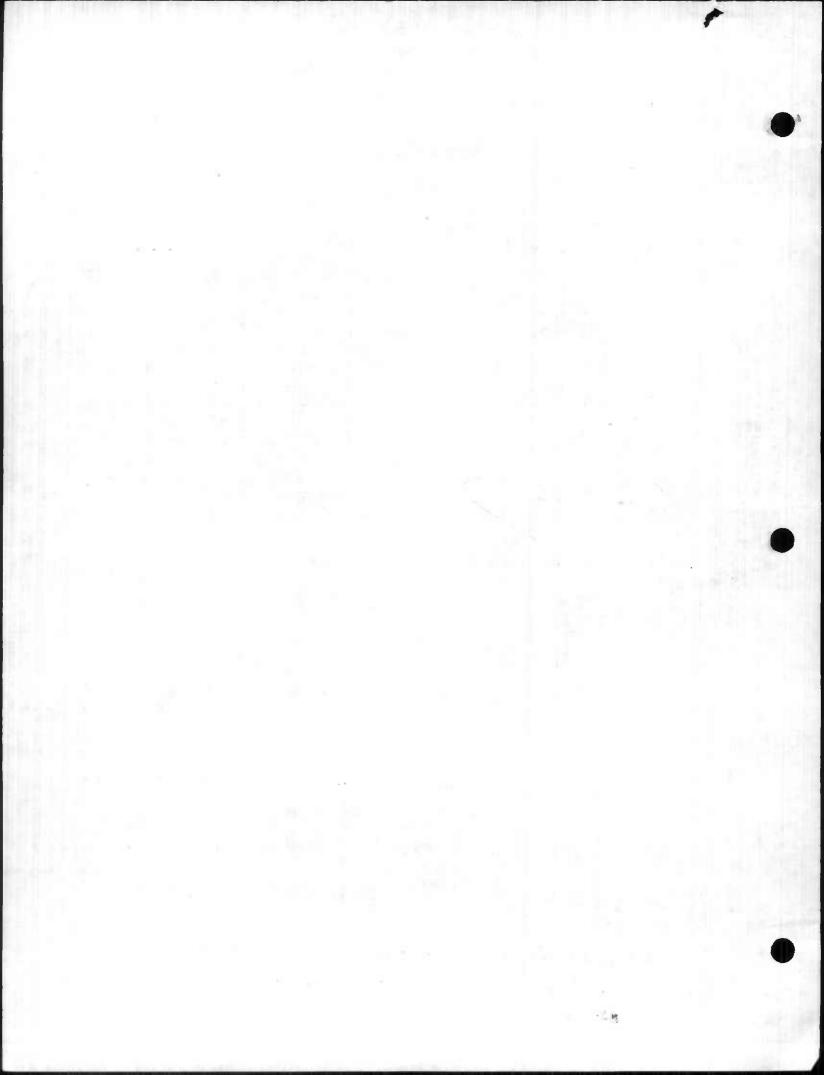
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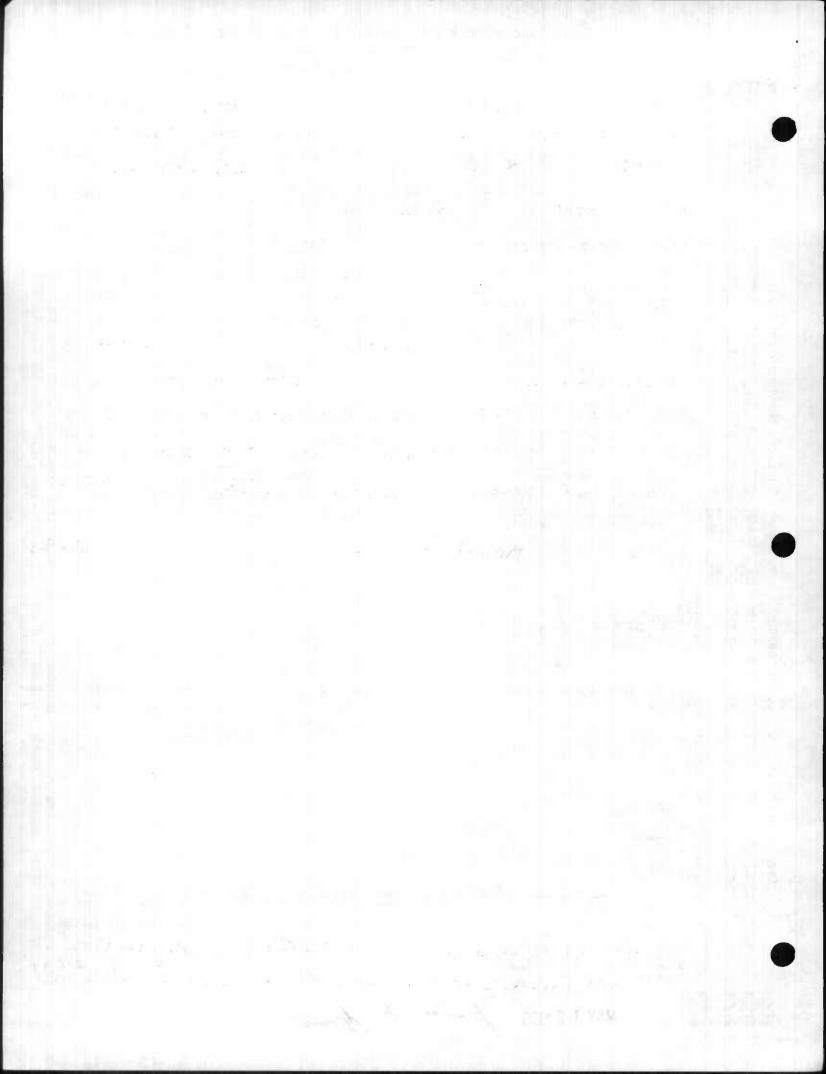


,			State of Maryla		tificate of			Reg. No.	17260
	dical	1. Decedent's Name (First, Middle, Las HENR I 4e. Feclity Neme (If not institution, give	EONAMI			Ab City Town or	2. Dete of De Month MA	Dey 10	Yeer 1-30 Am
Exan Funer Directo	al	Mariner Healthcar 5. Social Security Number 6. Sr 577-14-1396	e of Gr. Laur	e1 :. lest birthdey) Yrs.	If Under 1 Year Months Deys	4b. City, Town, or  Laure1  If Under 24 Hrs  Hours Min.	8. Date of Bird	Princ	of Deeth  e Georges  9. Birthplace (State or Foreign Country), Louisburg, NC
laryland show		Usual Residence of Decedent  10e. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
the Ma 28a-f	Director	MD Prince G  10e. Street and Number	eorges Gle	narden	1				1 X Yes 2 □ No
with with		8622 Johnson Ave			10f. Zip Code 20706			10g. Citizen of V USA	Vhat Country?
72 hours effer death with the Manyland natural; or tems 23a or 28a-f show dical Examiner must be notified at	by Funeral	11. Maritel Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Wes Decedent Ever in I Armed Forces? 1 ⊠ Yes 2 □ No if Yes, Give Year or Dates: unkn		Vas Decedent of H Yes, specify Cube		Specify Yes or No to Rican, etc.)		e - American Indien, kk, White, etc.
	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondery (0-12) 1 2	ucation		lent's Usuel Occup kind of work done OO NOT use retired	petion during most of world)	rking	16b. Kind of Bu	
nd 2 should be filed within and Mantai Hygiene.  It is marked other than traumatic event, the Mantai event, the Mantain event,	To Be Co	17. Fether's Neme (First, Middle, Last)  Joseph Leonard				18. Mother's Ner Mary Wa	me (First, Middle,	-	
Mar 12 sh h and r is m		19e. Informent's Name/Reletionship (7			g Address (Street				
		Carmen Campbell/N  20e. Method of Disposition  1 Buriel 2 Cremetion 3 Cl  4 Donetion 5 Other (Specify	20b. Removel from State	Plece of Dispo- cemetery, crem	Perrywo sition (Neme of netory or other plea oln Cemet	ce)	Dete 5-15-99		City or Town, Stete
Baltimo permit. Page Department of Important: If any injury or	- ACTION	21. Signature of Funeral Service Licens		Ma Ma	Neme end Addre TShall s	ss of Fecility Funeral	Home,		m. 191
Physicial /Medica Examine	r	Immediate Ceuse (Final disesse or comp composition) of heart feilure. List only composition is a composition of the composition	se P	i Sor es e consequence		g, such es cardie	c or respiretory er	rest,	Approximete Interval Batween Onset end Death
entificate be executed ding physician and se es the bunal-transit	/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest	c	or es e consequ					
death certification of for use e	Iclan	Dort II Other elgoifteent conditions	atility that to do the least of						İ
s that the	by Physician/M	Pert II. Other significant conditions con	1 //		lw disa			/	tribute to the cause of death?  3 Probably 4 Unknown
ew requires to see a see	Completed						24e. Wes perfor	en eutopsy rmed?	24b. Were autopsy findings evailable prior to completion of cause of deeth?
certificate he		Of Was and the state of		<u> </u>			1 🗆 Y	es 2E No	1 ☐ Yes 2 ☐ No
Physician: This certific	To Be	25. Wes case referred to medical exeminer?  1 Yes 2 No	Hospitel: 1 Inpatient 2	ER/Outpetlent	3□ DOA Oth	or.	oth <i>(Check only o</i> iome 5 ☐ Resid		or (Specify)
Affer	Certification:	27. Menner of Deeth  1 Neturel 5 Pending Investigation	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl			ow Injury occurre	
Hospital or 24 hours afte Funeral Directaly filled in	edical Certifi	3 Suicide 4 Homicide  29e. Certifier (Check only one) (Check only one) (Check only one)	28e. Plece of Injury - At h building, etc. (Special strains) are the best of my known or the bests of examine	y) owledge, deeth	occurred et the tim	ne, dete end plece plnion, deeth occu	City or Tow	m, Stete)	er or Rural Route Number,  nner as steted.  Ind due to the cause(s)
To the within ? To the comple	Mex	29b. Signature and little of certifier	end menner steted.		29c. License	number (		29d. Date signed	(Month, Day, Year)
(10)		30. Nagperand address of person who or	mpleted cause of deeth (Iter	m 23e) (Type, F	9/11	11/C	are//	MI	20785
S: Regis	ate	31. Dete filed (Month, Day, Year)	3. Registrer's Signa	ature				, ,,	(10)

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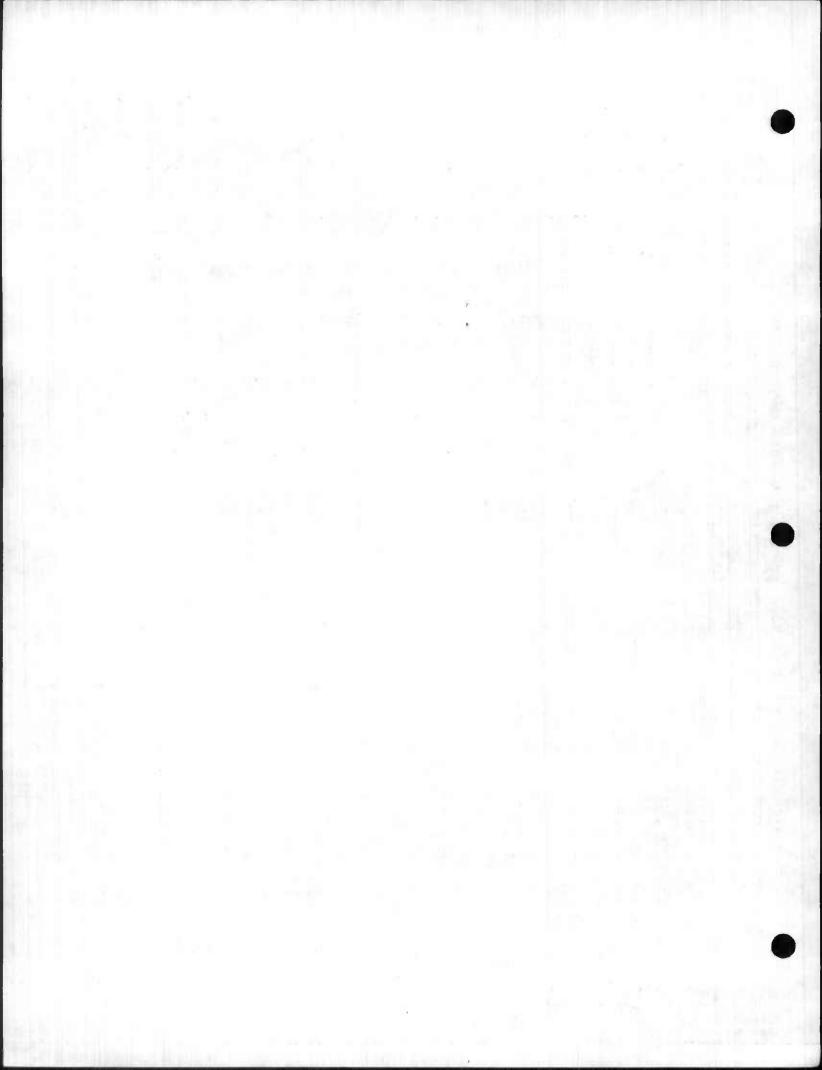
Please Type or Print in Biack indeiible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Amended Item 23a, Part I Per Phy., 5/12/99, Carroll County, wj1 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death 11:00am **Physician** Marie ester May 1999 /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 3017 B Oak Green Circle Ellicott City Howard If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth Months Deys Hours Min. July 18 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) 5. Sociel Security Number 262–28–6339 **Funeral** 1□ M 20 F Months 1915 Yrs. Va. **Director** Usual Residence of Decedent with the Maryland 10a. State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic avent, the Medical Examinar must be notified at Md Howard Columbia 1 ☐ Yes 2X No Director 10f. Zip Code 21044 10e. Street end Number 6150 Foreland Garth Apt. 120 10g. Citizen of Whet Country? USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23s any injury or other traumatic avent, the Manager Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11. Meritel Stetus 1 ☐ Yes ②ONo If Yes, Give Yeer or Dates: 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 XNo Specify: Specify: White þ 3€Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker domestic 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) George William Hensley Lucinda Ophelia Meadows 19e. Informent's Neme/Beletionship (Type, Print)
Thelma Kovalyak (daughter) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 3017B Oak Green Circle, Ellicott City, Md 21043 20b. Plece of Disposition (Neme of 20c. Location - City or Town, Stele 20e. Method of Disposition Springfield Cemetery 1 X Buriel 2 ☐ Cremation 3 ☐ Removal from Stete 5-15-99 Sykesville, Md 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility Haight Funeral Home & Chapel 21. Signeture of Funerel Service Licensee Paige Hought Herbert P.O. Box 195 Sykesville, Md 21784 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** 2 Wecks /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as e consequence of) Physician/Medical Examiner Congestive Heart Failure attending physician and for use as the burial-transit The law requires that the death certificate be axecuted Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Rheumatoid Arthritis Due to (or as a consequence of): ed by the a Part II. Other stanificant conditions contributing to death but not resulting in the underlying ceuse given in Pert f. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 254io 3 Probably 4 Unknown by 24b. Were autopsy findings aveilable prior to Completed 24a. Was en eutopsy performed? peens completion of ceuse of death? certificata has director, page 2 1 ☐ Yes 2 300 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatlent 3 DOA this funeral 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Certification: After 1 Naturel 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation after death. within 24 hours after death To the Funeral Director; A completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) and manner as steted.

2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, dete end piace, and due to the ceuse(s) end menner steted. 29e. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number 0 T(DW25m) 30. Name and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) 11055 Lttle Partuxer W.III.Am my uess 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture Registrar



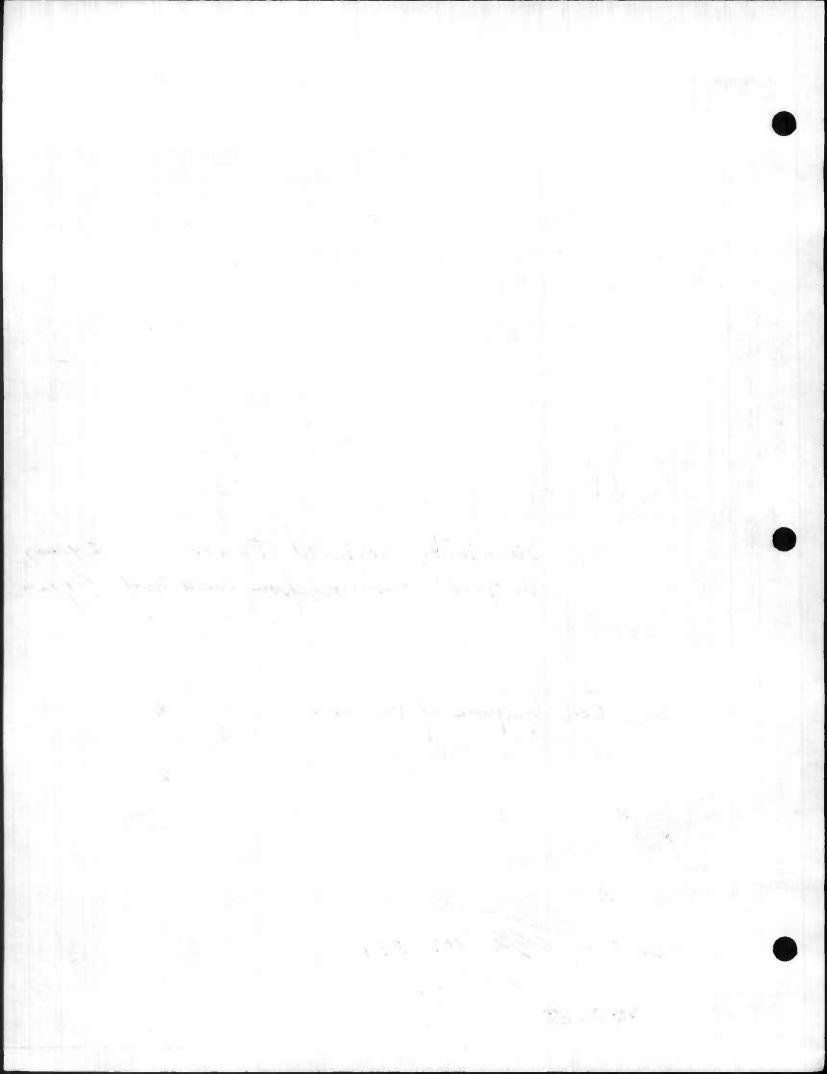
Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. Amended # 19a, Ms. 5/13/99, Allegany County State of Maryland / Department of Health and Mental Hygiene

3 (13(1			Ce	ertificate of	Death		Reg. No.		SECOY.	
Dhuaisian	1. Decedent's Neme (First, Middle, Li	nst)				2. Date of 8 Month		Year	3. Time of Death	
Physician /Medical	MABEL M. LEWI	S				MAY	10 19	999	1910	
Examiner						wn, or Location of De				
8	SACRED HEART		un do ná foliable de	v) If Under 1 Year		BERLAND		LEGA		
Funeral Director	7	Sex 1 □ M 2 F 7. Age (In y	ors. last birthday	Months Days		Min. (Month,	le of Birth onth, Day, Year) PENNSYLVANIA PENNSYLVANIA			
/land	10a. Stete 10b. County	10c.	City, Town or I	Location				1	0d. Inside City Limits	
efter deeth with the Menylan or fisms 23a or 28a-f show refer must be notified at Funeral Director	MARYLAND ALLE	GANY	CORRI	GANVILL 10f. Zip Code	E		10a Citizen of	1 ☐ Yas 2 1 No		
123a or				215			USA			
5 . S	3 ☑Widowed 4 ☐ Divorced	12. Wes Decedent Ever in Armed Forces?  1  Yes 2 No If Yes, Give Yeer or Detes:	13 U,S.	i. Was Decedent of If Yes, specify Cut		gin? (Specify Yes or I i, Puerto Rican, etc.)	No- 14. Rad Ble Specif	ce - Amaric ck, White, by:		
72 and of	15. Decedent's E (Specify only highest gr		(Giv	edent's Usual Occur e kind of work done DO NOT use retire	durina most	t of working	16b. Kind of B	lusiness/Inc	dustry	
A Paris	Elementery/Secondery (0-12)	College (1-4or 5+)		The state of the state of	90)		OHW H	OME		
tal Hygie d other event, the	17. Father's Neme (First, Middle, Last	2)	HOOS	EWIFE	18. Mothe	or's Name (First, Midd	OWN HO			
Mental Hygie wrked other i mitc event, tr	HADDY D CODD					LOPE CON		,		
and Men and Men and Men and Men To	19a Informant's Neme/Reletionship	(Type, Pnint)	19b. Mei	iling Address (Stree	et and Numbe	er or Rural Route Nun	nber, City or Town	, Stete, Zip	Code)	
and a	CHARLEW LEWIS/	SON	P.0	. BOX 2	13,CO	RRIGANVI	LLE, MD	215	24	
Pages 1 nent of Hs int: If Iten iny or oth	20a. Method of Disposition  1 Buriel 2 Cremetion 3 5 4 Donation 5 Other (Speci	Removel from Stete	cemetery, cr	position (Name of ematory or other pla ST MEMO	RIAL	13,1999 PARK	20c. Location			
permit. Pa Departmen Important any injury 2008.	2) Signature of Funeral Service Lice	nsee Q + L l	H	AFER CH	APEL	OF THE E	ILLS MO	ORTU	ARY	
	23a. Pert1. Enter the disease of com shock, or heert failure.	one ceuse on each line.							Approximate Interval Between Onset and Deeth	
Physician / /Medical	Immediate Cause (Finel	//	,	0,00				- P		
Examiner	disease or condition resulting in deeth)	· Itcu	te		mou	ung		-	2 days	
<u> </u>		Due to	o (or es a cons	equence of):				İ		
executed an and riel-transit	Sequentially list conditions,	b. Due to	o (or es a conse	equence of):				1		
physicien and sthe buriel-transit	if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	C								
Bu W	resulting in death) Last	Due to	(or es a conse	equence of):						
0 23 2	Pert II. Other algnificant conditions of	contributing to death but not	resulting In the	underlying cause g	iven in Part I.	. 23b. Di	d tobacco use co	ontributa to	o the cause of death?	
igned by i be detact	Colon Ca	reinoma				1(	Yes 2 No	3 Prof	bebly 4 Unknown	
been s should should	Congestive	Heart	Fall	uve			es an autopsy normed?	av co	ere autopsy findings eilable prior to impletion of cause death?	
The le						10	Yes 2 No	10	☐Yes 2☐No	
certificate has rector, page 2 Be Comp	25. Was case referred to medical				26. Place	of Death (Check onl)	y one)	1		
this ce al direc	axaminer?	Hospitel: 1 Inpatient 2	ER/Outpati	ent 3 DOA	ther: 4 Nu	rsing Home 5 🗆 Re	sidence 8 🗆 Oti	her (Specif	y)	
Attending Physician: or death. ector: After this carificial, the funeral director, by the funeral director, iffication: To Be (	27. Menner of Death  1. Netural 5 Pending 2 Accident investigation	28e. Dete of Injury (Month, Day Year)	28b. Time tnjury	Wo	ury et ork? ]Yes 2 □ I		e how injury occu	rred		
tal or Attending P is effer death. af Director: After t led in by the funers Certification:	3 Suicide 6 Could not be determined		t home, ferm, s ecify)	street, fectory, office		28f. Location City or 7	(Street and Num own, State)	ber or Rure	l Routa Number,	
To the Hospital or Attending Physician: The law within 24 hours effect death. Within 24 hours of Director: After this cartificate has completely filled in by the funeral director, page 2. Medical Certification: To Be Comp	29e. Certifier 1 Certifying Pr (Check only one) 2 Medicat Exam	nyalcian: To the best of my k niner: On the basis of exam and menner stated.	nowledge, dee	oth occurred at the tinvestigation, in my	ima, date an opinion, deal	d place, and due to the	e cause(s) end m e, date end place,	anner es s	tsted. the ceuse(s)	
Me Me	29b. Signeture and little of mirtifier	11/1		29c, Licen	se number		29d. Dete signe	ed (Month,	Day, Year)	
5	VIAMORA	6/7	111	m D.	351	35 1	1A5//3	1/8	7	
20 0 1	30. Name and address of persen who	completed cause of deet (i	19m 23a) (Type	Print)	) / /	Cumbo.	1/11/1	1 11	in	
State	31. Dete filed (Month, Dey, Year)	32. Registrar's Sig	V(8)	rejou K	V _	UVI 176V	( an/	PL	Ψ	
Registrar	MAY 13 200	Marin Marin	100	A STATE OF THE STA	*					



State of Maryland / Department of Health and Mental Hygiene

				Cei	rtificate of	Death		R	eg. No.		1200
		1. Decedent's Neme (First, Middle, La	ist)					ate of Deal	h	Van	3. Time of Deeth
	Physician /Medical	Lucille Pa	ainter Lyons	5			Ma	lonth V	Day 17 1	Year 999	5:00 pm
	Examiner	4e Facility Neme (If not institution, gi	ve street end number)			4b. City, To	wn, or Location		4c. County	of Death	
		Sacred Heart He	ospital			Cumbe:			Alle	egany	7
	Funeral			(In yrs. last birthday)	If Under 1 Yea Months Day		Min. (A	ata of Birth fonth, Day,	Year)	9. Birthp	place (Stata or Foreign
	Director	21/-10-585/	10 M 20 F	87 Yrs.			Apr	. 29	1912	Vest	Virginia
	2	Usual Residence of Decedent  10a. Stete 10b. County	1	Oc. City, Town or Lo	cation						0d. Inside City Limits
	Alenyth and and an										1 √2 Yas 2 □ No
	with the Marylar s or 28a-f show be notified at Director	Maryland Allection   10e. Street and Number	any	Cumber	10f. Zip Code			1	Og. Citizen of W	That Coun	Λ
	The state of	617 Miller Ave				502			US		,
	ther death w r thems 23s kiner.must. Funeral	11. Maritel Stetus	12. Was Decedent Ev	er in U.S. 13.1			gin? (Specify )	es or No-			can Indian,
-	Fun Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2X No		Was Decedent of If Yes, specify Cu Y			, etc.)	100	k, White,	
050	ar. or	3 ☐ Widowed 4 ☐ Divorced	tf Yes, Give Year or Detes:		1□Yes 2ÔN	Specify:			Specify	Whit	e
9	72 hours after natural, or th fical Examin sted by Fu	15. Decedent's E		16a. Deced	dent's Usual Occ	upation	A of condina		16b. Kind of Bu	siness/Inc	dustry
21	ed within 72 ho yglene. er than 'naturn t, the Medical. Completed	(Specify only highest gr Elementery/Secondary (0-12)	College (1-4or 5+)	life.	kind of work don DO NOT use reti	e during most red)	e or working				
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P	Be sept	17. Father's Neme (First, Middle, Las				18. Mothe	er's Nama (Firs	t, Middle, I	Maiden Sumem	Θ)	
yla	Men Men artice	James M. Paint	er				Pearl N				
Maryland 21215-0020	2 sh and te m	19a. Informant's Neme/Reletionship	(Type, Print)		ng Address (Stre						Code)
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altimore	はのまる	20a. Mathod of Disposition  1 XBurial 2 Cremetion 3 [		20b. Plece of Dispo cemetery, crer pstburg	natory or other p	lece)					
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Bal	Sepa mpo my it and it	21. Signature of Funeral Service Lice	The state of the s		2. Name and Add						502
		- Wheeler	my							וב עני	
1		23a. Part1. Enter the disease, or con shock, or heert feilure. List only	one cause on each tra	e death. Do not ent	er the mode of d	ying, such as	cardiac or res	piratory em	est,		Approximete Intervel Batween Onset and Deeth
	Physician /Medical	Immediete Ceuse (Finel	J	7.10	,	/	1				9 110-
	Examiner	disease or condition resulting in deeth)	Disem in	ne real	arcin	oid	101	401			2 years
	a la la la la la la la la la la la la la		11.0.0	ue to (or as a consec	quence of):	~1	<b>'</b>	Cura	01 . La.	.1	Sue.
	ficate be executed physician and is the burial-transit.		bracijna	ue to (or as e conseq	y and	id h	our .	ma	9 1000	7	Jeny
ć	axac in and ial-tri	if any, leading to immediate cause. Enter Underlying	• 0	de to (or als e consec	luence ory.	- 1					
68760,	ifficate be execut g physician and as the burial-tran	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or Injury that initiated events	C	ue to (or es e conseq	uence of):						
	- OF 00 -	resulting in death) Last								i	
Box	death cert e attending ed for use sician/M		d							1	
	death ed fo	Pert II. Other algorificant conditions	contributing to death but	not resulting in the	nderlying cause (	given in Pert I	1.	23b. Did to	obacco use cor	ntribute to	o the cause of death?
P.0	The law requires that the death certaine has been signed by the attendin, page 2 should be detached for use Completed by Physician/N	Janco Cell	land love	e al 4	in ne	CK		1 🗆 Y	es 25 No	3 Pro	bebly 4 Unknown
	requires that he signed by hould be deleted by Pt	swift con	- Jan poo	~ /	u						
Records,	equir ben s bouid							24a. Was a perform		av.	era autopsy findings ailable prior to
ecc	law nas be e 2 ah					·					mpletion of cause death?
<u> </u>	The page							1 🗆 Y	es 2 No	10	☐Yes 2☐ No
'ita	ulcian: The law require certificate has been si irector, page 2 should is be Completed	25. Wes case referred to medical examinar?					of Death (Ch	ack only or	10)		
of Vital	Physicien: this certific inal director.	1 ☐ Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatier	IL 3LI DOA				ence 6 Oth		ý)
n	fler thunara	27. Menner of Death  1. Neturat 5 □ Pending	28a. Date of Injury (Month, Day )	(ear) 28b. Time of tnjury	W			Describe h	ow injury occum	ed	
Sio	eath. or: A the fu	2 ☐ Accident investigation			M 1	Yes 2					
Division	tal or Attending P. rs after death. al Director: After ti ied in by the funara Certification:	3 Suicide 6 Could not be detarmined		/ - At homa, farm, str ( <i>Specify</i> )	eet, factory, offic	8	281. L	ocation (Si City or Town	treet end Numb n, State)	er or Run	al Route Number,
	Co Cres a Co	20 0 17							10.11		
	To the Hospital or Attending Physician: The is within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page  Medical Certification: To Be Com	29a. Certifier 1 Certifying Pl (Check only 2 Medical Example)	nysician: To the best of e	caminetion and/or In	n occurred at the vestigation, in my	time, date an opinion, dee	or place, and do th occurred at	ue to the c the time, d	ause(s) and ma lata and place,	nnar as s and due to	tha cause(s)
	Mec Mec	29b. Signature and title of certifier	and manner stete	u.	29c. Lice	nse number		2	9d. Date signe	d (Month,	Day, Year)
		11/1	elip.	ud to	AD N	12/	21		May	18	1999
	m's	30 Name and address of names	completed source of doc	th (Item 22a) /Time	Print)	1200	)	1	144	10	[[]]
	3	30. Name end address of person who	M.D. aze	Richar	Walch	Road	( um	orlan	d Mr	) 2	1502.
	State	31. Date filed (Month, Day, Year)	32. Registrer	s Signatura	12013V	· LULLU	Cull O	rial			, 3- 30
	Registrar	MAY 2 0 190		a la		,					



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** MARY A. LAUER May 14 1999 6:10 pm /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. Counfy of Death **Examiner** Sligo Creek Nursing and Rehabiliation Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. Birthpiaca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 XF Yrs Director 95 6/7/1903 Pennsylvania 218-60-9299 with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. inside City Limits item 27 is marked other than "naturel", or itema 23a or 28a-f show other traumetic svent, the Modical Examinar must be notified at Yes 2 No Prince Georges Director MD College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3738 Marlborough Way 20740 United States 2 should be filed within 72 hours after death v and Mental Hygiena. Is marked other than "naturel", or itema 234 Funeral 12. Was Decedant Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 TNo Specify: Specify: þ 3 ☐Widowed 4 ☐ Divorcad White Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) 8 Homemaker Own home 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be Mabel Hoffmaster P James C. Quigley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is in eny Injury or other traun DDGs. E. Dianne Hatmaker/Niece 3738 Marlborough Way, College Park, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Buriai 2 Cremation 3 Removal from State 5/17 4 ☐ Donation 5 ☐ Other (Specify) Salem Cemetery Delta, PA 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA Letter the disease, or complications that caused the math. Do not enter the mode of dying, such as cardiac or respiretory arrest, is, or heart failure. List only one cause on each line. Intarval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical . COPDIVARU DISEASE 5 + 4 LARS Examiner Due to (or as a consequence of): Examiner attending physician and for use as the bunal-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disaase or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760 certificata be Physician/Medical Due to (or as a consequence of): P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? the th à 1 Yes 2 No 3 Probably 4 Unknown signed I ģ Division of Vital Records, ed bluods 24b. Were autopsy findings available prior to 24e. Was en autopsy performed? Completed peen completion of cause of death? has 1 Yes 2 DN6 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) al or Attending Physic s aftar death. Il Director: After this c 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) funeral 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending Investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 24 hours a Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 29a. Certifier edical 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one) To the To the F 29b. Signeture and this of certifier 29c. Licansa number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EFFRY 6525 6-6 MAN 32. Registrar's Signature 31. Date filed (Month, Day, Year) MAY 18 1999 Registrar

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Get Marine Section 1887 17

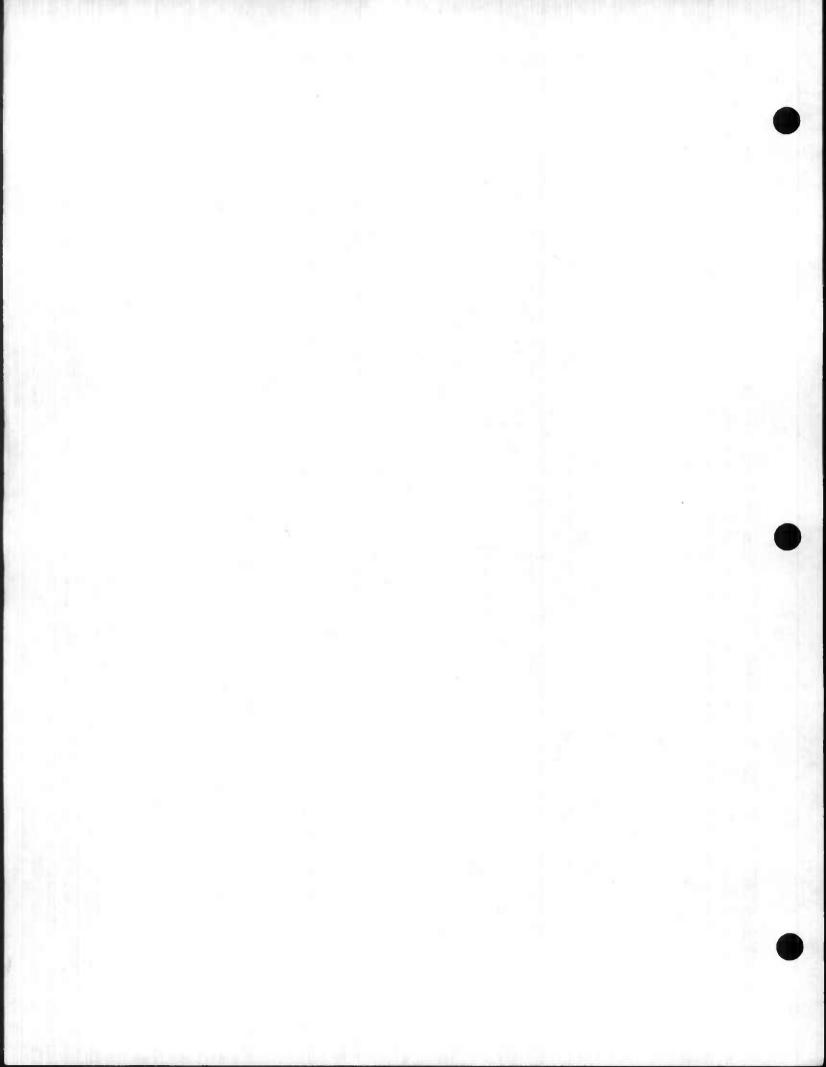
# VOID CERTIFICATE #

17265

SEE

CERTIFICATE M

15398



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death MAY 13, Day 1999 **Physician** BRUCE LYONS 2225 PM TAMES /Medical 4a Facility Neme (If not institution, giva straet and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Prince Frederick Calvert Calvert Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2□ F Months 59 Yrs. April 4, 1940 Maryland Director 214 38 9506 Usual Residence of Decadent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene. important: if Item 27 Is marked other than "naturel", or items 23a or 28a-f show any injury or other treumstic event, its Medical Expenses or 28a-f show page. 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Calvert Chesapeake Beach Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20732 USA 3930 Bayside Road Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 M/Yes 2 □ No If Yes, Give Year or Detes: 1 958 - 64 Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: white by 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) Elementary/Secondary (0-12) College (1-4or 5+) 12 equipment operator construction 18. Mother's Name (First, Middla, Maidan Sumame) 17. Fether's Name (First, Middla, Last) Marion Helen Paddy James Bruce Lyons, Jr. 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 19e. informant's Name/Reletionship (Type, Print) Marion H. Lyons, mother P.O. Box 694, N. Beach, MD 20b. Plece of Disposition (Nama of cematary, cramatory or other pl 20c. Location - City or Town, State 20e. Method of Disposition Date placa) 1 XBurial 2 Cremation 3 Removal from State So. Memorial Gardens 5-17-99 Dunkirk, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22 Name and Address of Facility Williams 4 Rausch Funeral Home, P.A., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death **Physician** (GACEN YAX Lail 8 morths /Medicai Immediate Cause (Final disease or condition resulting in death) **Examiner** Due to (or as a consequenca of) Examiner that the death certificete be executed hysician and the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of) physician Box 68760. Physician/Medical that initieted events resulting in death) Last Due to (or as a consequence of): 88 23b. Did tobacco uss contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. the 1 Yes 2 No 3 Probably 4 Unknown signed by d by 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy Completed peen : The law has 200 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No certificate or Attending Physician: Be 25. Was case referred to medical examiner? 26. Piece of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this : After this funeral 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigetion 2 Accident after death Director: 6 Could not be determined 3 Sulcide 28f. Location (Streat and Number or Rural Route Number, City or Town, Stata) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Spacify) To the Hospie...
within 24 hours after
To the Funeral Dire 4 Homicide

15 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

BRUCE A - SILVER, and 110 HOSPITAL RD, SU. 110, PRINCE FRENCRICK, MD 20678

29c. License number

29d. Date signed (Month, Day, Year)

1 VA

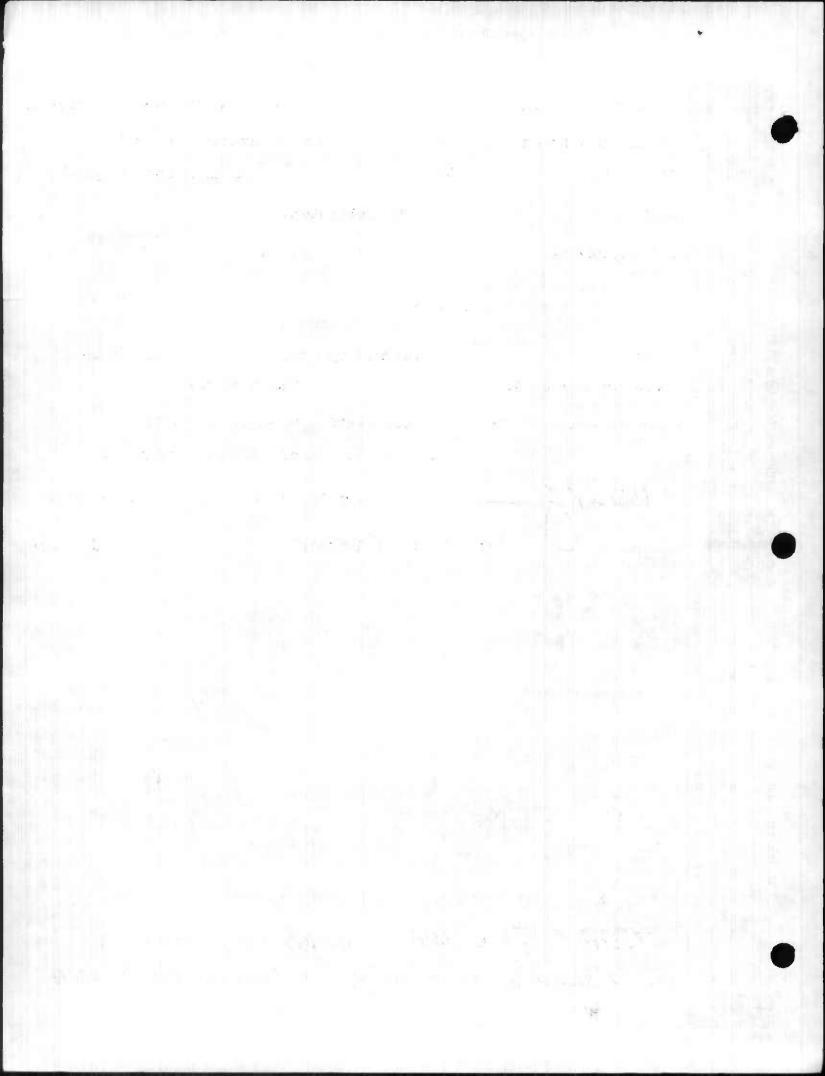
State Registrar

edical

29a. Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 1 9 1999 32. Registrar's Signature



10f. Zip Code

1□ Yes 2□ No

Homemaker

20b. Place of Disposition (Name of cametery, cremetory or other place)

Maryland National

1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes:

College (1-4or 5+)

21286

16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use ratired)

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

Forouz

302 E. Joppa Rd, Towson, Md. 21286

411 Kennedy St, N.W., Wash, D.C.

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)

	Print in Black Indo of Maryland / Depar		Health and M	Mental Hygi		17267
Decedent's Name (First, Middle, Last)     MAHNAZ	MOGHIMI			2. Dete of Death Month		3. Time of Death 3:05 Pm
4a Facility Name (If not institution, give street end no STELLA MARIS NURSI			4b. City, Town, or Le		4c. County of Deat	
5. Social Security Number 6. Sex 1□ M 2只F		If Under 1 Yeer Months Days	-	8. Dete of Birth (Month, Day, 11-5-58	Year) 9. Birt	hplece (Stete or Foreign untry)
Usual Residence of Decedent						
10a. State 10b. County	10c. City, Town or Loca	ation				10d. Inside City Limits

10g. Citizen of What Country?

Specify:

16b. Kind of Business/Industry

20c. Location - City or Town, Stata

5-8-99 Laurel, Maryland

28t. Location (Street and Number or Rural Route Number, City or Town, Stete)

29d. Dete signed (Month, Dey, Year)

21093

14. Race - American Indian, Black, White, etc.

White

Iran

18. Mother's Neme (First, Middle, Meiden Surneme)

22. Name end Address of Facilitiniversal Mortuary Inc.

Esfandiary

**Funeral** Director

**Physician** 

"natural", or items 23s or 28s-f show

traumatic event, the Medical Examiner must be notified at altimore, Maryland 21215-0020 permit. Pages 1 and 2 ahouid be filled w
Department of Health and Mental Hygien
Important: If Item 27 is meriked other the
any injury or other trainment.

1999

Mahmaz Maqhimi

**Physician** Examiner

> the burial-transit pue attending physicien for use as the buria signed by the all Records, P.O. should should page 2 certificate director this

Division of Vital or Attending Physician: After this death. To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fi

/Medical Examiner Completed Be Medical Certification: To

/Medical 4a Facility Name (If not institution Examiner STELLA MARI 5. Social Security Number 089-60-6185 Usual Residence of Decedent 10a. State 10b. County Baltimore Directo Maryland 10e. Street and Number 302 E. Joppa Rd. Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1- Never Married 2 Merried 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 17. Father's Name (First, Middle, Last) Be 2 Samad Moghimi t 9a. Intormant's Neme/Relationship (Type, Print) Mir Samad Moghimi -Father 20e. Method of Disposition Buriel 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Physician/Medical þ

11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death Breast Cancer Due to (or as a consequenca of): Due to (or as a consequenca ot): Due to (or es a consequence ot) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 3 Probably 4X Unknown 1 ☐ Yee 2 ☐ No 24b. Were autopsy tindings available prior to 24e. Wes en autopsy performed? completion of cause of death? 1 Yes 2 XNo 1 ☐ Yes 2 ☐ No 25. Was case reterred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Yes 2 No

Registrar

MAY 1 0 1999

1 Yes 2 No

6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

27. Manner of Death

1 XNatural

2 Accident

4 Homicide

29b. Signeture end title of cartifie

31. Dete tiled (Month, Day, Year)

3 Suicide

29e. Certifier (Check only one)

> Tariq Mahmood, 2300 Dulaney Valley Rd., Timonium, MD Registrar's Signeture

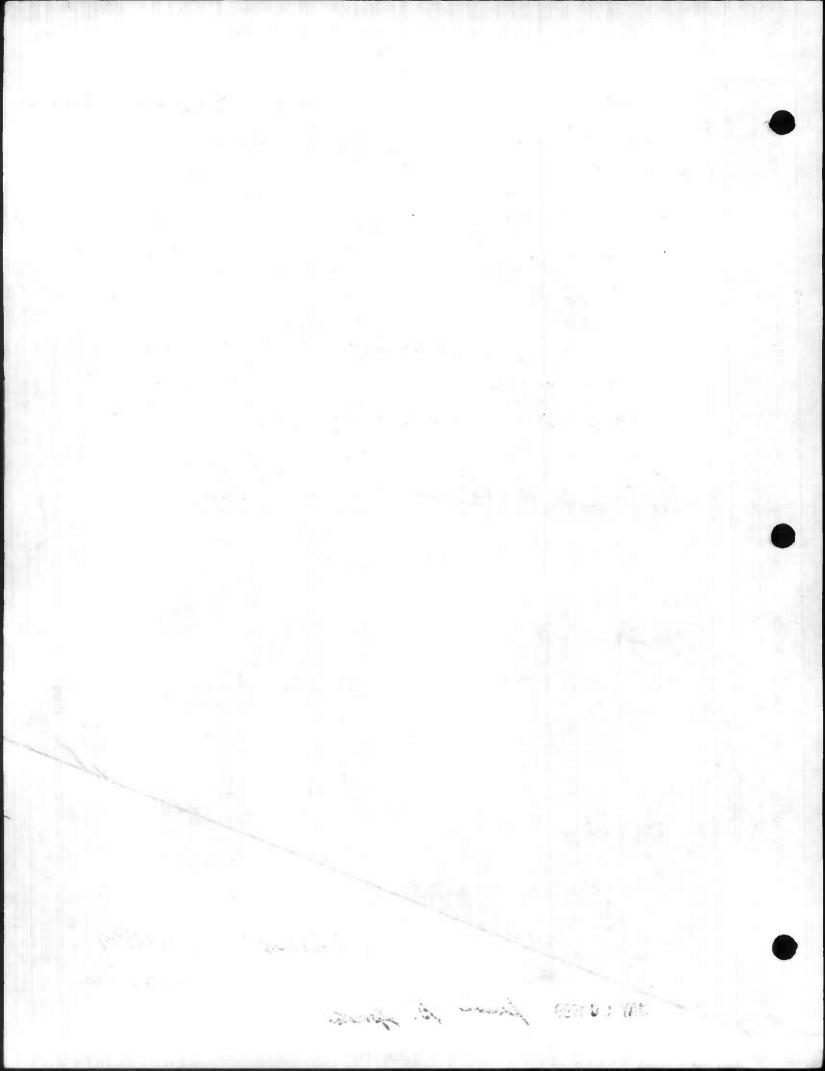
28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify)

1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, dete end pleca, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

29c. License number

D43725



State of Maryland / Department of

Health and	Mental Hyg	iene	0			- 0
f Death	R	eg. No.	V.	1 7	1	0.0
	2. Data of Deal			3.	Tima (	of Deat
	MAY 6,	1999	Year	2	04	0
	A 1141 A 100 A 14					

**Physician** /Medical Examiner

**Funeral** Director

show 288-1 8 Norms 23a "natural", or Hygiene. other than

72 hours after Department of Health and Mental Hygis Important: If Item 27 is marked other any injury or other traumatic event, II Pages 1 and 2 should be **Physician** 

Baltimore, Maryland 21215-0020

physician and s the burial-transit that the death certificate be executed Box 68760. P.O. 5 bengis d be det Records, peen page 2 certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director,

Certificate of 1. Decedent's Neme (First, Middle, Last) Jeremy E. Morris 4a Facility Name (If not institution, give street and number) PRINCE GEORGES CAMP SPRINGS MALCOLM GROW HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Yaar If Under 24 Hrs. Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 8. Data of Birth (Month, Day, Year) Days 1XM 20 F Months 577-82-0105 1976 30 23 Wash., Usual Residence of Decedant 10a. Stete 10b. County 10d. Inside City Limits 10c. City. Town or Location 1 XYas 2 No Prince George's Suitland Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20746 United States 4503 Rena Road, #101 Funeral 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 Yes 2 No If Yes, Giva Year or Dates: 1 Nevar Married 2 Married 1 Yes 2 No Specify: Specify: Black. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A Unemployed 12th 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Be Gwendolyn E. Fitzgerald Dewayne Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gwendolyn Fitzgerald - Mother 4503 Rena Rd., #101; Suitland, MD 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Data 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 5/12/99 Forest Hills Cemetery Clinton, MD 22. Nama and Addrass of Fecility 21. Signature of Eunaral Sarvice Licenses Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 ewar MM Entar tha disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, of heart failure. List only one cause on each line. Approximata Interval Between Onset and Death /Medical Immediata Causa (Final · Multiple Gunshot Wounds to Chest disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immadiata cause. Entar Undarlying Cause (Disease or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of) Physician/Medical Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy tindings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No Be 25. Was casa referred to medical 26. Placa of Death (Check only one) examiner? 1⊠Xas 2□ No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Inpatient XXER/Outpatient 3 DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred Medical Certification: 28b. Tima of 28c. Injury at Work? 5 Pending invastigation 1 Natural Subject was shot 1 Yes 2 No 7:39 PM May 6, 1999 2 Accident 6 Could not be 3 Suicida 28e. Place of Injury - At home, tarm, street, factory, office building, atc. (Specify) 4500 block ROUA Roud 281. Location (Street and Number or Rural Route Number, City or Town, State) 4500 Dlock RENA Roud 4 Homicida FOUND IN WOODED AREA Svittand, MD Suitland, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2X Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier 29d. Data signed (Month, Day, Year) MAY 8, 1999 29b. Signatura and little of certifier 29c. License number O.C.M.E. Theodore 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

**DHMH 16 Rev 6/95** 

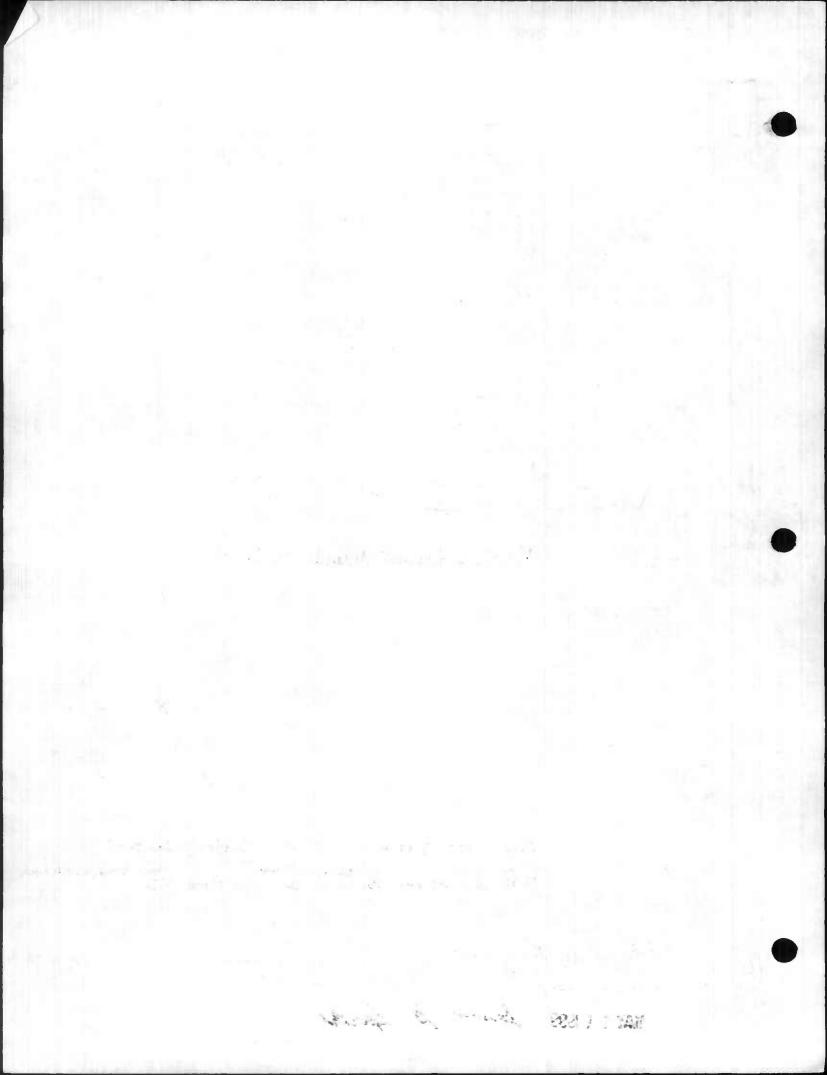
State Registrar

THEO DOPE MIKIN 31. Data filed (Month, Day, Year)

1 1999

32. Registrar's Signatura

111 Penn Street, Baltimore, Maryland 21201



	_			Cei	tificate of	Death			Reg. No.		
Physici	ian	Decedent's Name (First, Middle, Last)						<ol><li>Date of De Month</li></ol>	eath Day	Year	3. Time of Death
/Medic		Charles Edward Mc				4b. City, Tow		Mav	8 1	999	6:37 an
Examir	ner	4e. Fecility Name (If not institution, give s	street and number)			4b. City, Tow	m, or Loc	ation of Deal	th 4c. Coun	ty of Deeth	
		Doctors Comm			If I Index 1 Vees	Lan			Pr	ince	George's
Funeral		5. Social Security Number 6. Sex	M OFF		If Under 1 Year Months Days	Hours	Min	8. Dete of Bi (Month, D	av. Year)	9. Birtho	place (State or Foreign htry)
Director		578-84-7999 AM Usual Residence of Decedent	30	0 113.				June 7	,1962	South	Carolina
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, or Medical Estaminer must be notified anones.		10e. State 10b. County	10c. Cit	y, Town or Lo	cation					1	0d. Inside City Limits
- 3	tor	Maryland Prince Ge	orgos Mi	tchell	ri 110						1 ☐ Yes 🎾No
28	Director	10e. Street end Number	orges MI	CCHETT	10f. Zip Code				10g. Citizen of	What Cour	ntry?
38	O.	10209 Bald Hill Ro	had.		2072	1			U.S.	7	
	Funeral		2. Wes Decedent Ever in U.		Vas Decedent of h	lispanic Origi	in? (Spec	city Yes or No	o- 14. Re	ce - Americ	
5 8		XXNever Married 2 Married	Armed Forces?		Yes, specify Cub		Puerto H	licen, etc.)		ack, White,	
- 1	l by	3 ☐ Widowed 4 ☐ Divorced	Yes, Give Year or Dates:		I□Yes 2ŪXNo	Specify:			Spec	ity: B1ac	:K
netu Okeal	Completed	15. Decedent's Educ (Specify only highest grade	etion completed)	18a. Deced	lent's Usual Occup kind of work done	ation	of workin	a	16b. Kind of	Business/Inc	dustry
	npi	Elementery/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retire	d)					
her ti	ပိ	47 February Marie / First Marie / 1 - 10	5+	Phys:	ician				Medica		
d off	Be	17. Father's Name (First, Middle, Last)							, Maiden Suma	ime)	
I Mer marke	2	Charles E. Moore, S				A		shingt			
ie m		19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailir	g Address (Street	and Number	or Rural	Route Numb	er, City or Town	n, State, Zip	Code)
m 27		Janice Moore/Moth		10209	Bald Hi	ll Rd.	Mit				
if ite		20a. Method of Disposition  XXX Burlai 2 ☐ Cremation 3 ☐ Re	emoval from State	emetery, cren	natory or other pla			Date	20c. Location		
tant:		4 □ Donation 5 □ Other (Specify)			l Cemete	_	-	14,199	9 Suit1	Land,	MD
Impor any ir		21. Signature of Funeral Service License	° 04. 10	22	. Name and Addre	ess of Fecility	Ced	ar Hil	1 Funer	al Ho	me, Inc.
. U = 6 G		Sorya Monetgoney	· Chestaa		111 Penns	_				MD 2	20746
		23a Parti, Enter the disease or complete shock, or heart feilure. List only on	cations that caused the death a cause on each line.	n. Do not ente	er the mode of dyir	ng, such as co	erdlac or	respiratory a	rrest,		Approximate Interval Between
nysician	1									1	Onset end Death
Medical xaminer		Immediate Cause (Final disease or condition resulting in death)	Progre	SSIV	EMI	ulti	foc	2/			
	<u>.</u>	resulting in death)	Progre	r as a conseq	uence of): /O	11/1/00	onc	onha	18007	The	
Sit	Examiner	b				01/101		Opino	,	0	
ate has been signed by the attending physician and page 2 should be detached for use as the bune-transit	xau	Sequentially list conditions, if any, leading to immediate	Due to (o	r es e conseq	uence of):						
physician and the buriel-transit		Cause (Disease or Injury								i	
phys s the	edical	that initieted events resulting in death) Last	Due to (or	as a consequ	uence of):						
ding se as	-	d.					- 7			i	
attending p	clar										
by the stached	Physician/M	Part II. Other significant conditions cont	ributing to death but not resu	ulting in the un	nderlying ceuse giv	ven in Part I.					the cause of death?
deta		Acute R	espinatore	A	MIST			1 🗆	Yee 2□ No	3 Prol	bably 4 Unknown
been signed be should be dete	d by			1				240 140	an autopsy	24h W	ere autopsy findings
shou	Completed							perf	ormed?	av	ailable prior to mpletion of cause
has Je 2	mp									of	death?
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director, pag	Be	25. Was case referred to medical examiner?	ospital:		Oth	200		(Check only			
this al di	. To	1 Yes 2 No ''  27. Manner of Deeth	1 ☐ Inpatient 2 2	ER/Outpatien 28b. Time of	I SLI DOA	4 LI NUIS			idence 6 🗆 O		y)
After fune	lo	1 Matural 5 ☐ Pending	(Month, Day Year)	Injury	28c. Injur Wor M 1 🗆			od. Describe	how injury occu	nied	
otor: A	cat	2 Accident investigation 3 Suicide 6 Could not be	28e Diece of Initial	ma fame at		Yes 2 □ No		of Loopties	(Street and M	har as O	I Pouto Atumba
Direc in by	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify		eu, ractory, office		28		wn, State)	iver or Hura	nl Route Number,
To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Sertifying Physi	alan. Task Street	ulada - d d			atairi				
Fun	edicai	(Check only one)	cian: To the best of my known: On the basis of examinat	wiedge, death ion and/or inv	estigation, in my o	me, date and pinion, death	place, ar	d at the time,	date and place	nanner as si , end due to	tated. the cause(s)
To the Funeral Direct completely filled in by	Me	29b. Signature and title of pertifier		. /	29c. Licens	se number			29d. Date sign	ed (Month	Day Near)
8 - 8		1 8/ 1	1/5	~	-	-				-/0	lac
2	-	auguste	A CHAR	Jun	7/10	10			0	18/	97
)		30. Name and address of person who cor	pleted cause of death (Item	23a) (Type,	Print)	18/	. 1	1	KRO	1	much
04		51. Date fligd (Month, Day, Year)	2 Registrar's Signa	140			004	4UCI	4 KO	LAR	MITH MO
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Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

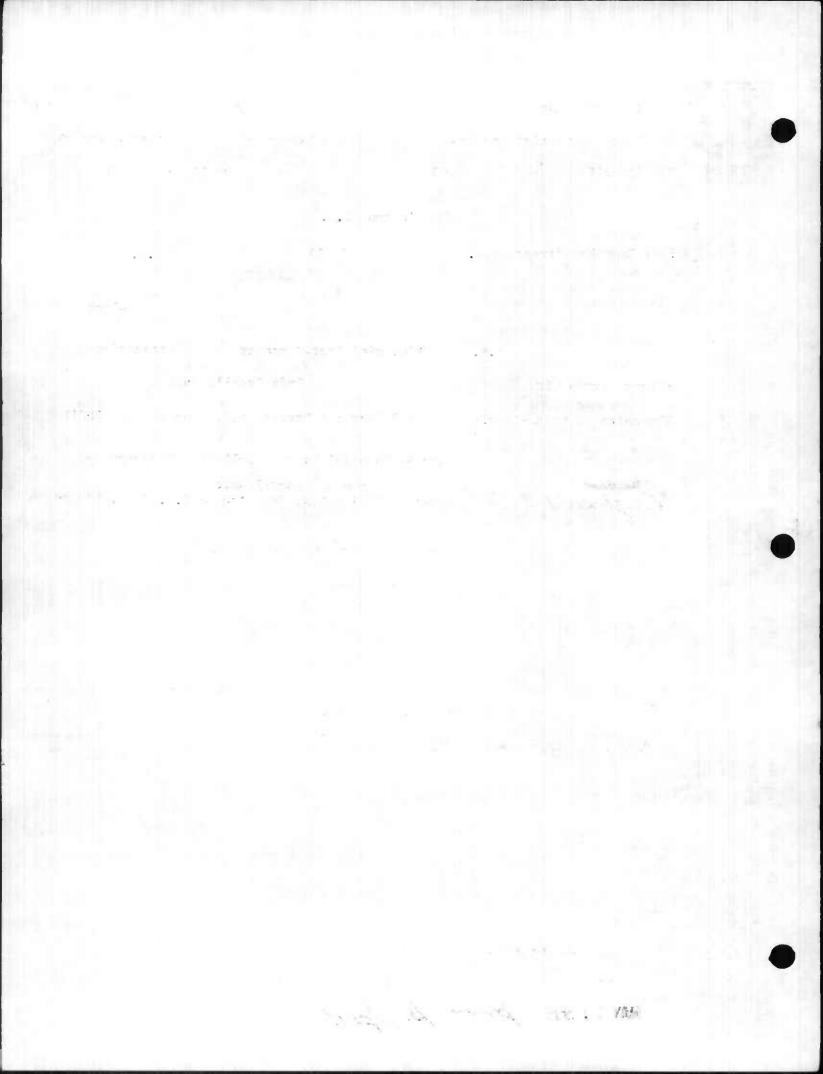
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					State of Ma	arylan		artment of rtificate o	Health and I f Death	Mental Hy	rgiene		7270				
			1. Decedent's Nan	ne (First, Middle, Las	st)	- 1				2. Date of De	eeth		3. Tima of Deeth				
	Physici		Albert N	Morris, J	r.					Month	Day	Yeer 999	12:50 PM				
	/Medic Examir				e street end number)				4b. City, Town, or				,,,,,,				
	LAGITIII	101	Washing	ton Advent	tist Hospi	ta1			Takoma,	MD	Mont	gome	ry CO.				
	Funeral Director		5. Sociel Security ! 254-42-9		ex 7. Age	65 (In yrs. 1	last birthday) Yrs.	If Under 1 Yee Months Day		8. Dete of Bi (Month, D	rth ay, Year) 1 34	9. Birthp Court GA	elece (State or Foreign stry)				
	p ,		Usual Residence of	of Decedent 10b. County		100 Cit	, Town or L	nostion				1	0d. inside City Limits				
	shor shor	2	Iva. State	100. County				ton, D.C					TV Yes 2 □ No				
	the N	ect	10e, Street end Nu	umbar		W C	SHITHE	10f. Zip Code			10g. Citizen of W	/het Cour	41				
	with with	ā			reet, N.W.				011	8.00	U.S.A.		itty (				
	eath	Funeral Director	11. Marital Status	granam be	12. Was Decedent E	Ever in U	S 13			pecify Yes or N			an Indian,				
20	should be filed within 72 hours efter death with the Meryland Ind Mantel Hygiana. merked other than "naturet", or items 23s or 28s-f show metic event, the Modical Exercises must be notified at	by	1 Never Mer	ried 2 Married	Armed Forces? 1 1 Yes 2 □ N If Yes, Give	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:		<ul> <li>S. 13. Was Decedent of Hispanic Origin? If Yes, specify Cuben, Mexican, Pu</li> <li>1 ☐ Yes 2 ☒ No Specify:</li> </ul>		o Rican, etc.)	Blac Specify	k, White,	etc.				
21215-0020	tural		O ED WILDOWS	15. Decedent's Ed			16a. Dece	dent's Usual Occ	upation		16b. Kind of Bu	Blac Isiness/In					
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g	offied other	Bec	17. Father's Name	(First, Middle, Last)					187 - 102-1111		e, Maiden Sumam	e)					
<u>a</u>	Mantel Marked of Matter eve	10	Albert	Morris, S	r.				Lyda E	stelle 1	Hannah						
Maryland	2 should end Mar Is marks sumatic			Name/Relationship (					et and Number or Ru								
	# 27 P		Thomasi	na H. Can	tz-Cousin				m Street,	N.W.,	Wash. D.	C	20011				
Baltimore,	If item or oth		20a. Method of Dis		Removal from State	20b. P	lace of Dispersion of the lace	osition (Neme of matory or other p	place)	Date	20c. Location -	ation - City or Town, Stete					
Ē	Pages nart of ant: If its ury or o			5 Other (Specify		Har	mony	Memoria1	Park	5-15-99	Lando	ver,	MD				
a	Desmit. Depart import any inj		21. Signature of F	uneral Service Licen	isea		2	2. Name and Add	ress of Fecility r Funeral	Home							
ш	20199		Res	insold	I. Col	die	201				S.E.,Wa	sh, 1	DC 20020				
	Physician /Medical Examiner  puo unios/ proper equal- prop	Examiner	Immediate Ceuse disease or conditi- resulting in deeth)  Sequentially list or if any, leading to I cause. Enter Und	(Finel on on onditions, mmediate lerlying	b. Pa	Due to (o	P/R r as a conse MC r as a conse	quence of):	4 FAI	LURZ	ĉ	rest, Approximate Intervel Between Onset and Death					
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	death e atte	sicie	Part II. Other sign	ificant conditions o	ontributing to death bu	ut not resi	ulting in the	inderlying cause	given in Part I.	23b. Dic	i tobacco use cor	ntribute t	o the cause of death?				
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	ificet or, p	BeC	25. Was case refe	rred to medical					26. Place of De		V						
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ion of	nding Phy th. :: Aftar thi a funaral		27. Menner of Dee		28e. Date of Injui (Month, Day	ry	28b. Time ( Injury	28c. Injury et 28d. Describe how injury occurred									
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	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edicai C	29a. Certifier (Check only one)		ysician: To the best on ninar: On the basis of and manner sta	examina											
	Vithin Fo th	Me	29b. Signature and	d title of cartifier	TA	TIAN	SPINT	29c. Llos	ense number		29d. Date signe	d (Month),	Dey, Year)				
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State Registrar

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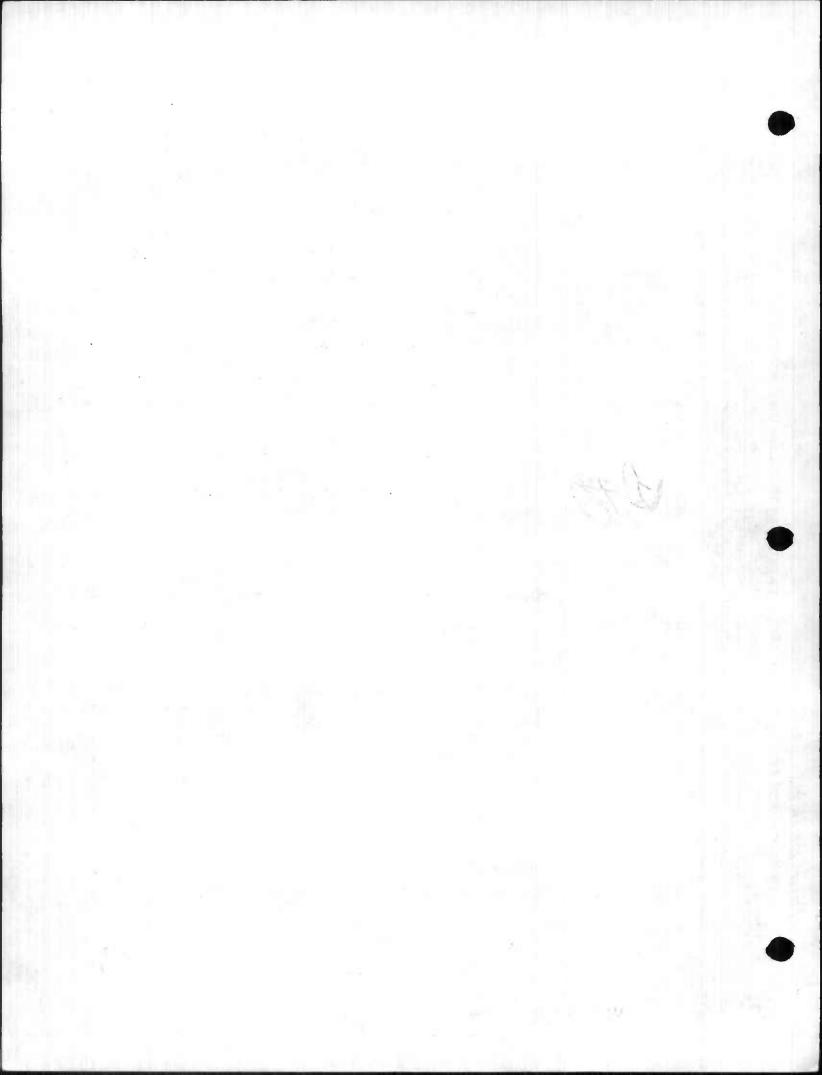
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31. Date filed (Month, Day, Year) 32 Registrar's Signeture



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month 47 **Physician** KENNETH RAYMOND MULLER, SR. 5 99 /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** CARROLL COUNTY GENERAL HOSPITAL WESTMINSTER CARROLL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1**∑** M 2□ F 68 Yrs. 214-28-7252 Director 4/27/1931 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23s or 28s-f short the Medical Examiner must be notified at CARROLL WESTMINSTER 1 Yes 2 No MD. Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Norms 23s 1031 MULLER RD. 21157 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) hours after 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 natural, or 1 Yes 2X No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER & YARDMAN LUMBER COMPANY 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Be Department of Health and Mental introportant: If them 27 is marked or any injury or other traumatic eve CHARLES MULLER LULA EDNA YINGLING 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GLADYS V. MULLER -WIFE 1031 MULLER RD., WESTMINSTER, MD. 21157 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State SALEM U.M. CHURCH CEM. 5/13/99 WESTMINSTER, MD. 5 ☐ Other (Specify) 4 Doneti Licensee 22. Neme and Address of Fecility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 e, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediete Ceuse (Finel disease or condition resulting in deeth) EMBOLIC DAYS STROKE Examiner Due to (or es a consequence of): Examiner YEARS ATRIAL FIBRILLATION physician and s the burial-trans Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as e consequence of): Box 68760 CONGENITAL HEART DISEASE Physician/Medical Due to (or es e consequence of): for use as 950 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown signed t by 24b. Were autopsy findings available prior to 24a. Wes an eutopsy performed? Completed completion of cause of death? page 2 1 Yes 2 XNo 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) Hospitel: 1 Inpatient To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After t 1 Netural 5 Pending Investigation 1 | Yes 2 | No death. 2 Accident Director 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 6 124 hours after control Fundamental Director Section 124 hours after 124 hours 4 Homicide ò To the Hospital o within 24 hours at To the Funeral D Medical 29a. Certifier (S-Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier MS DO 1663 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 906 WASHINGTON FIOCED WESTMINSTER MD VR 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State MAY 1 3 1999 Registrar

ULIBR, KENNETH



		State of M	Maryland /		ent of F cate of	lealth and M <i>Death</i>	lental Hy	giene g	0 1	7272
	1. Decedent's Name (First, Middle	e, Last)					2. Date of De	eath	Year	3. Time of Death
Physician /Medical	I. LOUISE N	<b>IURRAY</b>					Month MAY	Day 14	1999	0012AM
Examiner	4a Facility Nama (If not institution	n, give street and number	r)		- 4	4b. City, Town, or Lo	ocation of Deat	h 4c. Coun	ty of Death	
	ATLANTIC GENI					BERLIN			ESTER	
Funeral	5. Social Sacurity Number	6. Sex 7. A	ge (In yrs. last		ndar 1 Year hths Days	Hours Min.	8. Date of Bi	rth ay, Year)		laca (Stata or Foreign ltry)
Director	177-14-5422 Usual Residence of Decedent		82	115.			12-21-	1916	PHIL	ADELPHIA, PA
w ta	10a. State 10b. County		10c. City, T	own or Location	1				1	0d. Inside City Limits
Meny Meny fied to tor	DELAWARE SUSSI	EΧ	SEL	BYVILLE						1 ☐ Yes 2X No
death with the Menyland ms 23s or 28s-f show rmust be notified at	10e. Street and Number				f. Zip Code			10g. Citizen o	f What Cour	ntry?
h with	RD#2 BOX 31				1997	5		U.S	. A .	
	11. Maritai Status	12. Was Deceden		13. Was D	ecedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecity Yes or No Rican, etc.)		ace - Americ	
she she	1 Never Married 2 Marr	ied 1 ☐ Yes 2 ☐ if Yes, Give	No		es 25 No			Spec	eify:	
\$\final \text{5-0020} \\ 15-0020 \\ 7.2 hours effer death with the Menylen "natural", or fems 23a or 28a-f show edical Exprises must be incitited at letted by Funeral Director	3 ¼ Widowed 4 □ Divorced	Yaar or Dates						16h Kind of		WHITE
n 72 Inet	15. Deceden (Specify only highes	it grade completed)		6a. Decedent's (Give kind of life. DO No	of work done OT use retired	during most of work d)	ring	165 TATE MOTOR	VEHTC	I.F.
d 21215-0020 d 21215-0020 filed within 72 hours effer they marked to the mont, the Medical Examine of Completed by Fu	Eiementary/Secondary (0-12)	Coilege (1-4o		SECRETA				INSPEC		
ind 212 be filed with tal hygiene. d other than	17. Fether's Name (First, Middle,	Last)				18. Mother's Nam	e (First, Middle	, Maiden Sume	eme)	
- 050e m	RALPH FUTO	CHER				FLOSSIE	POWELL			
Aaryla 2 should and Men Men Men Men Men Men Men Men Men Men	19a. Informant's Name/Relations					and Number or Rur				
ore, M	NORMA MUIR/COU	SIN		3207 SAG e of Disposition		, MARLTON				
Pages 1	20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation		cemi	etary, cramatory	or other ple		Date	20c. Location		
	4 Donation 5 Other (S		MARI			CEMETERYC	05-18-9	9 OCEAN	VIEW	DELAWARE
Balt Beaut, Depart Important importa	21. Signature of Familyal Service	7001				UNERAL SECHER ST.,	ERVICES	, LTD.		
	23a. Part Chier the disease, br	complications that cause	ed the death. [						AWARE	19945 Approximate
Physician	23s. Part Chier #19 disease or shock, or heart failure. List	only one cause on each	line.			•				Interval Between Onset and Daath
/Medical	Immediate Ceuse (Final disaese or condition	4			ca.d:	. 10.1	die		1	465.
Examiner	resulting in deeth)	a	Due to (or es	e consequence	e of):	ovascular	Olisce		1	7:3:
99 executed in and ial-transit		<b>-</b> b							į	
S/14/99 Box 68760, asth certificate be executed ettending physician and for use as the burial-transit	Sequentially list conditions,	<b>1</b>	Due to (or as	e consequence	e of):					
ician bunia	Cause (Disease or Injury	С.							i	
S//4 OO/lookeesting the provided in the provid	that initiated events rasulting in death) Last		Due to (or as	a consequence	e of):				i	
Centiling and in Maria		d								
death death is etter	Part II. Other significant condition	na contributing to death	but not resulting	a in the underly	ring cause giv	ven in Part I.	23b. Dic	I tobacco use	contribute t	o the cause of death?
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On of on of ding Phys. h. funeral d	1 Natural 5 Pendir 2 Accident investi	g (Month, E	Day Year)	Injury	28c. Inju Wo	rk? ]Yes 2□No				
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OLISE Division of the form of the funding P is after death.  In Director: After the funding of t	4 Homicide	building,	etc. (Specify)				City of To	JWII, State)		
Division of  Division of  To the Hospital or Attending Phy within 24 hours after death.  To the Funeral Director: After thi completely filled in by the funeral  Medical Certification: 1	29a. Certifier 1 Certifyir (Check only one)	g Physician: To the bes Examiner: On the basis and manner:	of examination	dge, death occu and/or investig	irred et the ti ation, in my o	me, date and piece, opinion, death occur	, and due to the rred at the time	e ceuse(s) and , date and plac	manner as s e, and dua t	stated. o the cause(s)
of the on the omple	29b. Signatura and title of certifip	_			29c. Licans	sa number		29d. Date sig	ned (Month,	Day, Year)
F S F Ö	> Sliph	er mo			D	141721		5/	4/99	
	30. Name and address of person	who completed cause of	f deeth (Item 23	3a) (Type, Print)				/	*[ * .	110
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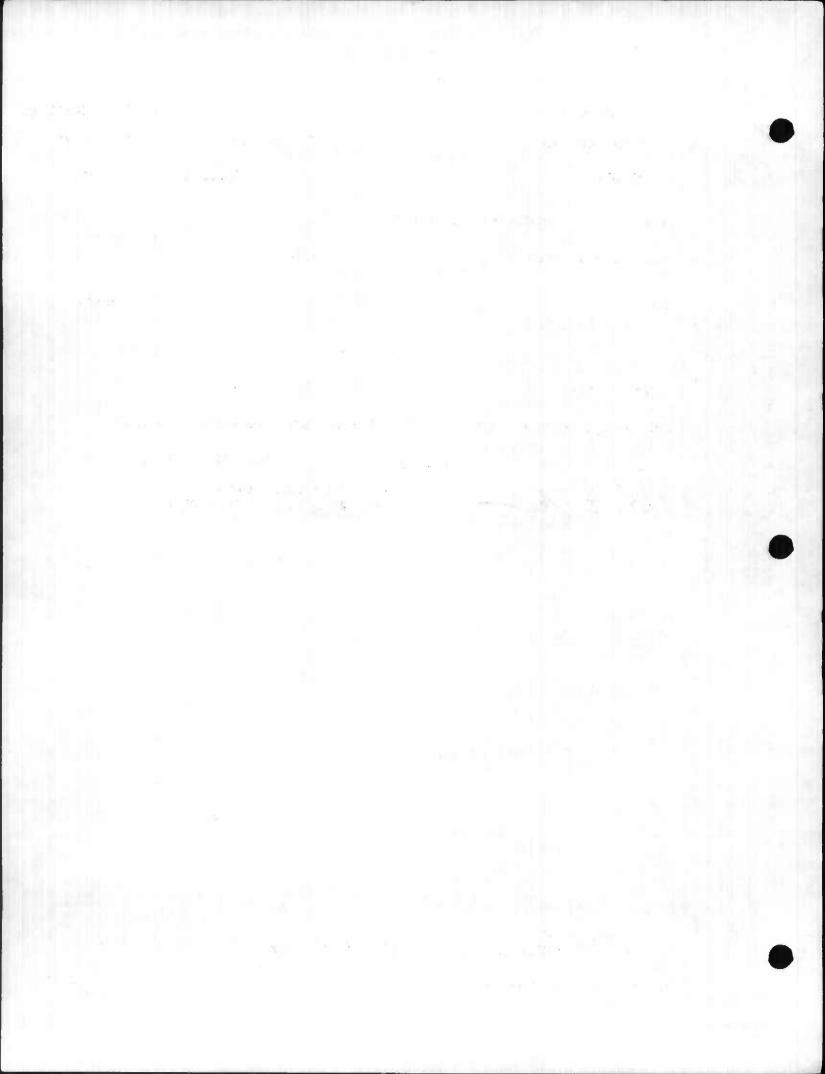
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Nama (First Middle Last) 2. Date of Daath 3. Time of Death Month **Physician** 1999 MAY 16 HELEN MARTE MILAM 10:30 AM /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, give street and number) Examiner FORESTVILLE PRINCE GEORGE'S 8111 REDVIEW DRIVE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours 1□M 200 F Yrs. Director 401-40-8614 April 4, 1932 Virginia 67 Usual Residence of Decedent the Merylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limita 28a-f show / is marked other than "natural", or flams 23s or 28s-f shot traumstic svent, the Medical Examinar must be notified at 1 Yes 2 No Maryland Prince George's Forestville Directo 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? with 20747 USA 8111 Redview Drive Funeral 72 hours efter death 12. Was Decedent Ever in U,S. Armed Forces? Was Dacadant of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yas 2X No If Yes, Give Year or Dates: 1 Never Marriad 2 Married Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: by White 3€Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within Elementary/Secondary (0-12) College (1-4or 5+) Own Home Housewife 8 Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be 2 should be fi Opal Howell Smith Howell 2 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 end 2 st Department of Health and Important: If Itsm 27 is n any injury or other traun 8111 Redview Dr. Forestville, MD 20747 Janice Faye Brown (Daughter) 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 □ Cramation 3 □ Removal from State 4 □ Donetion 5 □ Other (Specify) 5-21-99 Clintwood, VA Colley Cemetery 21. Signature of Funeral Service Liceasee 22. Name and Address of Facility J.H. Eberwein Mortuary M00173 4433 White Pls La White Pls, MD 20695 art1 Enter the disease, or complications that caused the control of the control o complications that causad the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Batween Onsat and Death Physician in obstructure lung desert /Medical Immediata Causa (Final disease or condition resulting in death) Examiner Examiner and I-trensit death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Box 68760. Physician/Medical Due to (or as a consequence of) attending 23b. Did tobagco use contributs to the cause of death? ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o. that the NO Yes 2 No 3 Probably 4 Unknown signed by neumonia Records, þ requires 8 24b. Were autopsy findings available prior to 24a. Was an autopsy performad? Completed peen s complation of causa of death? aw certificate has The 1 Yes 2 No Division of Vital Physician: 25. Was casa referred to medical examiner? Be 26. Place of Death (Check only one) To Hospitel: Other: 4 ☐ Nursing Home 5 📆 Rasidence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 ☐ inpatient 2 ☐ ER/Outpatient 3□ DOA this funeral 28e. Dete of Injury (Month, Day Year) i or Attending Ph after death. 27 Manner of Death 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? 5 Pending Investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No the n 24 hours after dea ne Funeral Director pletely filled in by th 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Medical To the Hosp within 24 ho To the Fune completely fi 29b. Signature and litla of certifier 29c. License number 29d. Data signed (Month, Day, Year) 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print), 6510 GERARDO GA

State Registrar 1 9

1999

32. Registrar's Signature

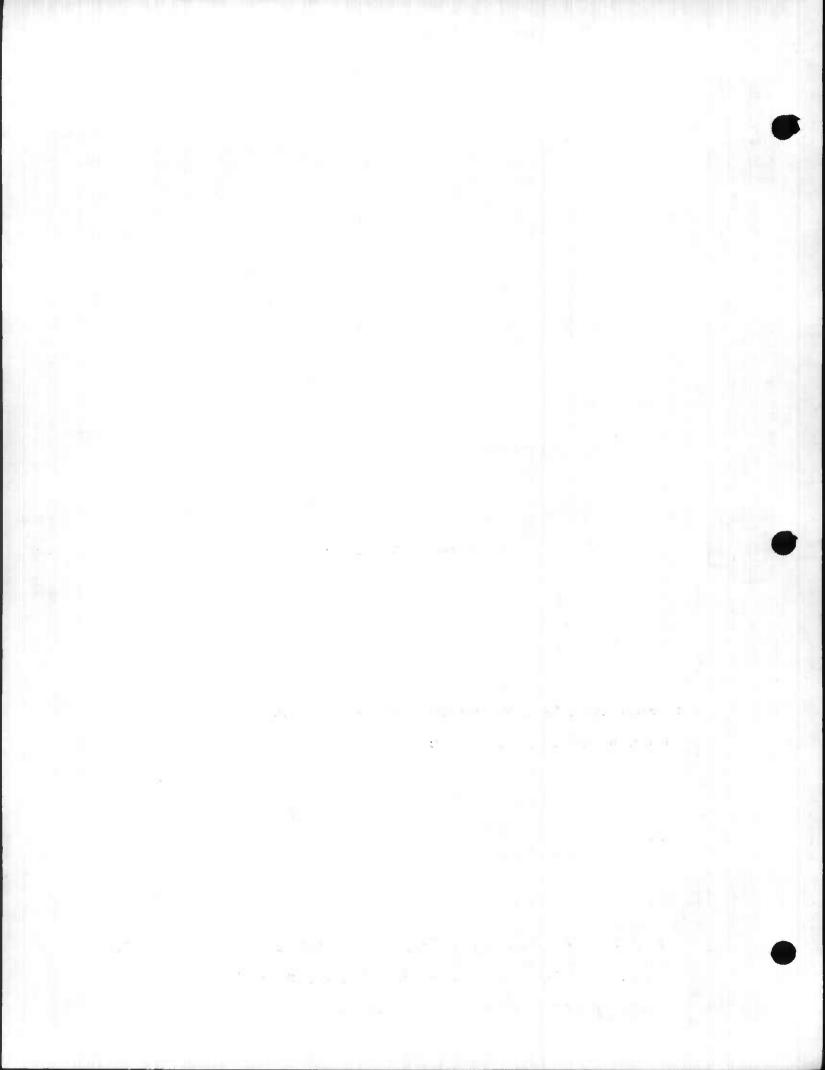


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Day 1999 ar **Physician** May 11, 11:43am McKenzie Frances /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner Grantsville Garrett Goodwill Mennonite Nursing Home If Undar 24 Hrs. 8. Data of Birth Hours Min. Mar. 13, Year 1908 7. Aga (In yrs. last birthday) If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1□M 20 F Months Days 173-09-5987 91 Yrs. Director Usual Residence of Decedent the Marylend r 28a-f show 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Yas 2 No Allegany Directo MD Cresaptown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours efter death with it Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Examination than any injury. 14022 Cedarwood Drive 21502 USA Funeral 12. Was Decedent Evar in U,S. Armad Forcas? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxicen, Puerto Ricen, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 📌 ☐ No Specify: Specify: white ģ **X**□ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Operator/Clerk Grocery Store 18. Mothar's Name (First, Middle, Maiden Sumema) 17. Father's Name (First, Middle, Last) Ruben Lease Hattie (Lease) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 585 Dennett Road; Oakland, MD 21550 19a. Informant's Name/Relationship (Type, Print) Wayne Johnson son-in-law 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/14/ Cresaptown, MD Lease Cemetery 28 Carper Fruneral Home P.A. Cumberland, Maryland 23a. Part1. Enter the disease, or compile tions that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each lihe. Approximate Interval Between Onsat and Death **Physician** Immediate Ceuse (Final disaasa or condition resulting in death) /Medical Acute Myocardial Infarct 1/2 hour Examiner Due to (or as a consequence of) Examiner ng physicien and as the buriel-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): certificata be exec Box 68760, Physician/Medical that initieted events resulting in death) Last Due to (or as a consequança of): ettanding esn P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably N Unknown Neoplasm right lung, Hypertension, Dementia, New stroke signed t Division of Vital Records, by 24b. Were autopsy findings available prior to 24e. Was an autopsy performed? Completed benign brain tumor removed years ago complation of causa of death? Wel er has paga 1 ☐ Yes 2 ☐ No certificata Physician: Be 25. Was case rafarrad to madical 28. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 45 Alursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred Hospital or Attending P1
 24 hours after deeth.
 Funeral Director: After the 28c. Injury at Work? Certification: 5 Pending investigation 1 DaNatural 1 ☐ Yes 2 ☐ No 2 Accident ector: / 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 6 Could not be determined 3 Suicida 28e. Place of injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 I Homicide To the Hospital c within 24 hours al To the Funeral C complataly filled 18 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner es stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier edicai (Check only one) 29d. Deta signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier D26650 5/12/99 Year 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PO Box 486 RU Margaret A. Kaiser MD Oakland, MD 21550 31. Date filed (Month, Day, Year) 62. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

MAY 18 1999



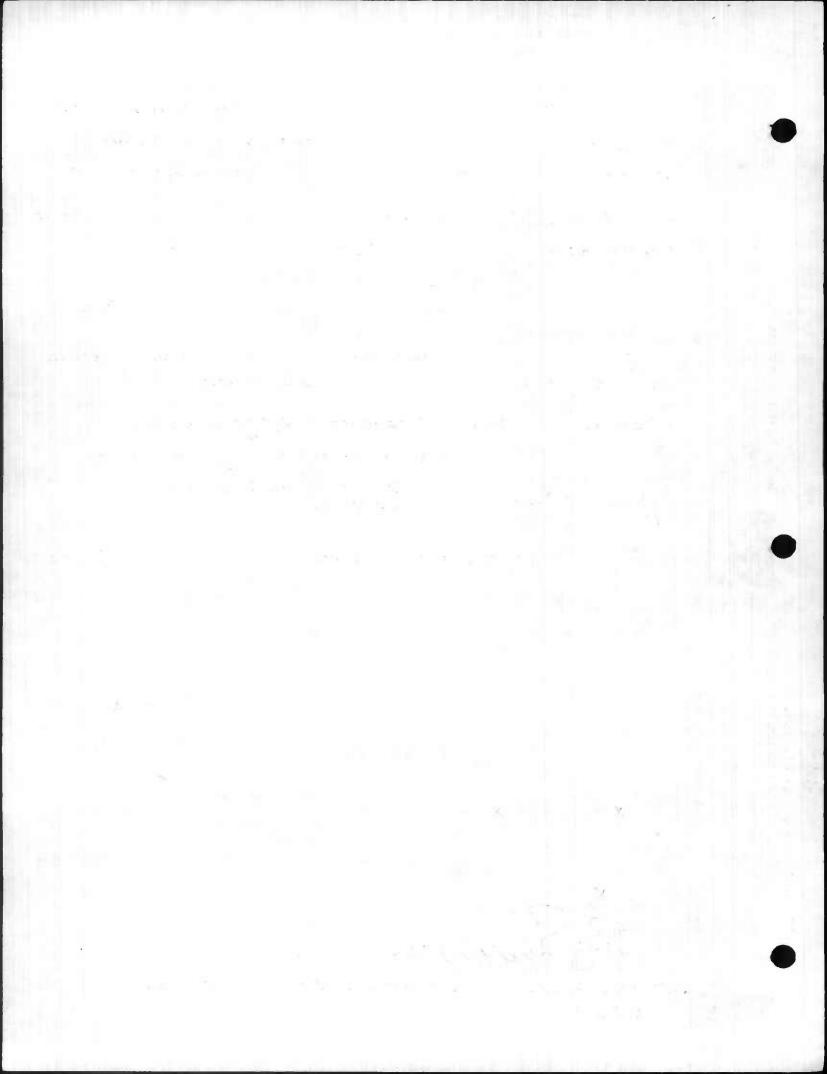
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Deeth Month **Physician** Wilson Smith Marshall 10, 1999 06:53 May /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not Institution, give street end number) 4c. County of Death Examiner ALLEGANY MEMORIAL HOSPITAL CUMBERLAND If Under 1 Year if Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dev. Year) Birthplece (Stete or Foreign Country) **Funeral** Min 150 M 2□ F Months Deys Hours Yrs. 212-12-8509 78 Director January 24 1921 MD Usuel Residence of Decedent with the Marylend 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show trsumstic event, the Medical Examiner must be notified at MD Allegany Lonaconing 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 48 W. Main Street 21539 USA pernit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: if ifen 27 is marked other than "natural", or items 23. any Injury or other traumatic event, the Med Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?
1 [Xyes 2 D No WWII if Yes, Giva Yeer or Detes US Army Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Rece - American Indian 11. Meritel Status Bleck, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🕱 No Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade complated) Elemantary/Secondary (0-12) College (1-4or 5+) Board of Education 10 0 Custodian 18 Mothar's Name (First Middle Malden Surname) 17. Father's Neme (First, Middla, Last) Robert Smith Marshall Leola Mae Loraw 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. informent's Neme/Relationship (Type, Print) V. Mae Nolan Sister 18 Campground Road, LaVale, MD 21502 20e. Method of Disposition 20b. Placa of Disposition (Neme of cemetery, cremetory or other piece) MayPete 12 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State Frostburg Memorial Park Frostburg, MD 4 ☐ Donetion 5 ☐ Other (Specify) 1999 21. Signeture of Funerei Service Licanii 22. Name end Address of Fecility any ir Eichhorn-McKenzie Funeral Home P.A. 8 9 Lonaconing, MD 23a. Fant. Enter the disease, or complications that caused the daeth. Do not anter the mode of dying, such as cardiec or raspiratory arrast, and the disease, or complications that caused the daeth. Do not anter the mode of dying, such as cardiec or raspiratory arrast, and the disease of the Approximata Intervel Between Onset end Deeth **Physician** /Medical Immedieta Ceusa (Finel diseasa or condition resulting in daeth) a. CA of Lung with Metastasis 3 months Examiner Due to (or es e consaquence of): Examiner physician end the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate causa. Enter Undarlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequenca of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as e consequence of): 98 attending esn signed by the a 23b. Did tobacco use contributa to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 32 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No þ 24b. Were autopsy findings available prior to Completed 24e. Wes an eutopsy peen s completion of cause of deeth? pege 2 s certificate 1 ☐ Yas No. 1 TYas 2 No After this certifical funeral director, I or Attending Physician: Be 25. Wes case raferrad to madical 26. Piaca of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 □ ER/Outpatient 3 □ DOA WILSON MARSHALL 28c. Injury et Work? Certification: 27. Menner of Deeth 28e. Data of Injury (Month, Dey Year) 28b. Tima of 28d. Describe how injury occurred 1 Neturei 5 Pending investigation n 24 hours efter death.

Ne Funeral Director: A pletely filled in by the fi death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 🕍 Certifying Physician: To the best of my knowledge, deeth occurred at tha time, date and piaca, end due to the causa(s) and mannar as stated. 29a. Certifier Medical completely er: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, deta and place, and dua to the cause(s) (Check only 2 Medicai To the F within 2 29b. Signeture and title of 29c. License number 29d. Date signed (Month, Dev. Year) 10, D16041 May 1999 who complated causa of death (Item 23a) (Type, Print) 30. Nama end eddress of nus MEMORIAL MEDICAL BUILDING CUMBERLAND MD TERRY WILLIAMS. M.D. 31. Deta filed (Month, Day, Year) 32. Registrer's Signeture State

DHMH 16 Rev 6/95

Registrar

MAY 1 3 1999



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** RALPH ANDREW MICHAEL MAY 16, 1999 9:25 p.m. /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Neme (If not institution, give street end number) Examiner MEMORIAL HOSPITAL & MEDICAL CENTER CUMBERLAND ALLEGANY If Under 1 Year 8. Dete of Birth Month, Day, SEPT 14 5. Sociel Security Number 9. Birthplece (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthdey) **Funeral** 1√2 M 2□ F Months Days Hours Min. 217-18-4730 75 Yrs. W. VA. Director Usual Residence of Decedent the Marylend r 28a-f show 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Ves 2 □ No ALLEGANY MARYLAND CUMBERLAND Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with 7 is marked other than "natural", or items 23s or traumatic event, the Modical Examiner must be a 21502 U.S.A. 1450 OLDTOWNE MANOR APTS. Pages 1 and 2 should be filed within 72 hours efter death neart of Heath and Mentel Hygiene.

In: If item 27 is marked other than "natural", or items 23 mills it item 27 is marked other than "natural", or other traumatic event, the Moulton Experience makes Funeral 12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 Ñ No If Yes, Give Year or Dates: 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 Never Married 2 Married Specify: WHITE 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: p 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade com 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) completed) College (1-4or 5+) Elamentery/Secondary (0-12) COLUMBIA GAS COMPANY COLUMBIA GAS 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be JAMES ANDREW MICHAEL VALLIE RANKIN 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Raletionship (Type, Print) LORNA L. MICHAEL WIFE 1450 OLDTOWNE MANOR APTS. CUMBERLAND MARYLAND 21502 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Dete 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Depertment of Important: If any Injury or DAVIS MEMORIAL PARK MAY 19, 1999 CUMBERLAND MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service 22. Name end Address of Fecility MERRITT-ADAMS FUNERAL HOME erritt 23a. Pert1. Enter the disease, or combicetions that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory errest, shock, or haart failura. List only one cause on each line. Approximete Intervel Between Onset end Death Physician /Medical Immedieta Ceusa (Final disease or condition resulting In death) CORONARY ARTERY DISEASE **5YEARS** Examiner Due to (or es e consaquence of): Examiner end I-transit the death certificate be executed Sequentielly list conditions, if eny, laading to immediate causa. Enter Underlying Cause (Diseese or Injury that initiated evants resulting in death) Lest Due to (or es a consequence of): physician er s the buriel-t P.O. Box 68760 Physician/Medical Due to (or es a consequance of): 98 nse signed by the 6 d be deteched f Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CHRONIC CHF Division of Vital Records, þ 24b. Were eutopsy findings evailable prior to Completed 24e. Wes an eutopsy performed? phode RENAL CELL CARCINOMA completion of cause of daeth? page 2 hes 1 Yes 2 No 1 Yes 2 No certificate Hospital or Attending Physician: funeral director, 25. Was case raferred to medical exeminer? Be 26. Place of Deeth (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yes 2 No P 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 28d. Dascribe how Injury occurred 27. Manner of Death 28b. Time of 28c. Injury et Work? Certification: 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No efter death. Director: Af Investigation 2 Accident To the Hospital or Atter within 24 hours efter des To the Funeral Director completely filled in by th 6 Could not be datermined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, atc. (Specify) 4 Homicida 12 Certifying Physician: To the best of my knowledge, death occurred at the time, deta end piece, end due to tha causa(s) end menner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29e. Certifier Medical (Check only one) 29d, Date aloned (Month, Dev. Year) 29b. Signature and title of certifier 29c. License number ustas Jones 14865 30. Name end eddrass of person who completed causa of deeth (Item 23e) (Type, Print)

500 MEMORIAL AVE., STE. 201 CUMBERLAND, MD 21502

Registrar

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ROBUSTIANO J. BARRERA.

MAY 18 1999

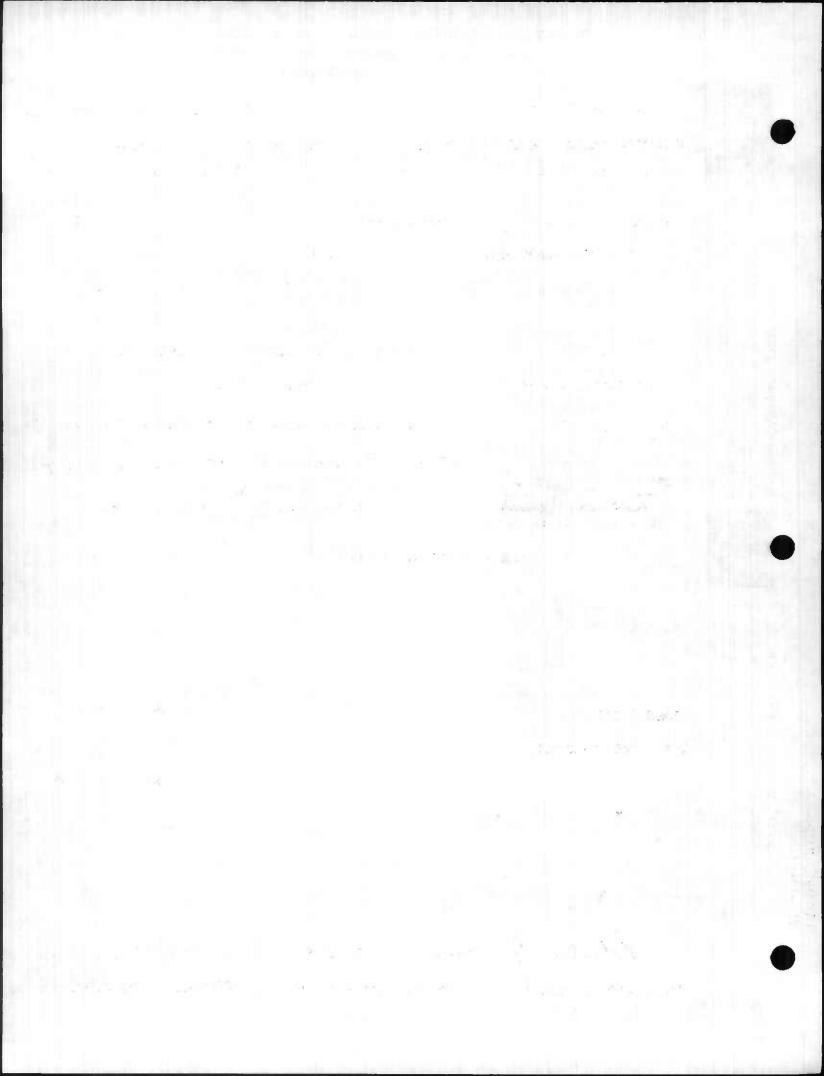
31. Dete filed (Month, Dey, Year)

M.D. 500 ME

RALPH

MICHAEL

217-18-4730



State of Maryland / Department of Health and Mental Hygiene

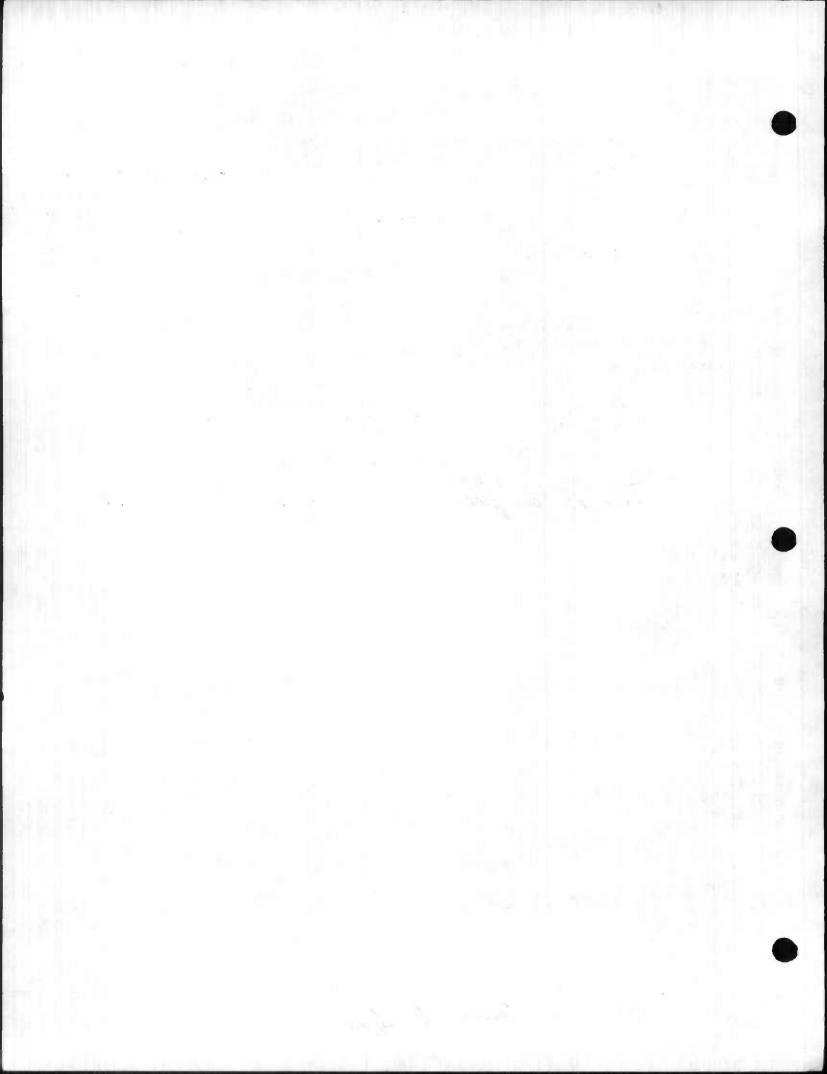
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-		FROSTBURG  5. Social Security Number	6. Sex	-	HOME s. last birthday)	If Under 1 Ya	FROSTBU		ALLE	+	lana (Ctata au Fau
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the Maryler 28a-f show	to	MARYLAND ALLE	EGANY	FR	OSTBURG						1 <b>K</b> ) Yes 2□
C N	Funeral Director	10e. Street and Number				10f. Zip Code	9		10g. Citizen of	What Coun	ntry?
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Mental Mental arked o	To H	JAMES H. SMIT	rh -				ELIZA	BUTTS			
end A	-	19a. Informant's Name/Relation	onship (Type, Print)		19b. Mailing	g Address (Stre	et and Number or F	ural Route Numb	er, City or Town,	, State, Zip	Code)
Heelth er am 27 le other trau		JANE WOLFORD	SOCIAL I	DIRECTOR	FROST	BURG VI	LLAGE NUR D 21532	SING HOM	IE, 1 KA	YLOR	CIRCLE
Department of Heel Important: If Itam 2 any injury or other once.		20a. Method of Disposition			Place of Dispos	iltion (Nama of		Date	20c. Location	- City or To	wn, State
ant of the your		1X Burlal 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other		om State	cemetary, crem		AL PARK 5	/19/00	FROSTBU	IPC N	(D)
Department of mportant: If its any injury or o		21. Signature of Funeral Service		P F			dress of Facility	710/33	FROSIDO	iko, r	10
Depa Impo		6.7	0		S	OWERS F	UNERAL HO	ME, P.A.			
		23a. Part1. Enter the disease, shock, or heart failure. L	Out	212	6	O W. MA	IN ST., F	ROSTBURG	G, MD 21	532	Approximate
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. A	CUTE	MY0 (or as a consequ	CARD	,	NAAK		// <	Interval Between Onset and Death
	fical Examiner	disease or condition resulting In death)  Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Causa (Disease or injury that initiated events	a. A	O RON Due to	myo	CARD penca of): ART pence of):	,			/ <	Interval Between
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death.  ctor: After this certificate has been signed by the attending physician end y the funeral director, pega 2 should be datached for use es the burial-transit	Certification: To Be Completed by Physician/Medical	disease or condition resulting In death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaasa or rinjury that initiated events resulting in deeth) Last  Part II. Other significant conditions are summer?  1 Yes 2 No  27. Mannar of Death 1 Netural 5 Pencinder Significant Conditions are summer? 2 Accident Invas: 3 Suicide 6 Coul determined to the summer of Death 1 Homicide Coul determined to the summer of Death 1 Netural 1 Suicide 1 Coul determined to the summer of Death 1 Netural 2 Accident 1 Netural 2 Suicide 1 Death 1 Netural 2 Suicide 2 Suicide 3 Suicid	titons contributing to	Due to Due to Due to Due to Due to Object of Injury Conth, Day Year)  The best of my king the best of my king Due to Object of Injury Conthe Due to Object O	(or as a consequence of the cons	Jence of):  Jence of of):  Jence of of of):  Jence of of):  Jen	given in Part I.  26. Place of De Other: 4 Nursing I jury at Jork?  — Yes 2 — No	23b. Did 1 24a. Was performent to the control of th	tobacco use co Yes 20 No en eutopsy rmed?  Yes 2 No one) denca 6 Oth now injury occur.  Street and Numb vn, State)	antribute to 3 Prote  24b. We ave cor of c  1 C	Interval Between Onset and Death Onset and Dea
after death.  Director: After this certificate has been signed by the attending physician end in by the funeral director, pega 2 should be datached for use es the burial-transit	To Be Completed by Physician/Medical	disease or condition resulting In death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or injury that initiated events resulting in deeth) Last  Part II. Other significant conditions are summer?  1 Yes 2 No  27. Mannar of Death 1 Netural 5 Pence Invas 3 Suicide 6 Could determine 1 Conditions are summer?  29a. Certifier (Check only Medical Medical Conditions)	titons contributing to  Hospital:  Hospital:  (Maing ding stigation do not be rmined 28e. Planting Physician: To the and m.	Due to Du	(or as a consequence of the cons	pence of):  and of the pence of):  and of the pence of):  and of the pence of):  and of the pence of):  and of the pence of):  and of the pence of):  and of the pence of the	given in Part I.  26. Place of De Other: 4 Nursing I jury at Jork?  — Yes 2 — No	23b. Did 10 24a. Was perfect ath (Check only of the control of the	tobacco use co Yes 20 No en eutopsy rmed?  Yes 2 No one) denca 6 Oth now injury occur.  Street and Numb vn, State)	24b. We ave correct of control of	Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset

Changelyten How Days of May 1. 194 ट्रमारह में समीमा और जान हिरापर, स्पेरतराज्य, जारे अंडर द

State of Maryland / Department of Health and Mental Hygiene

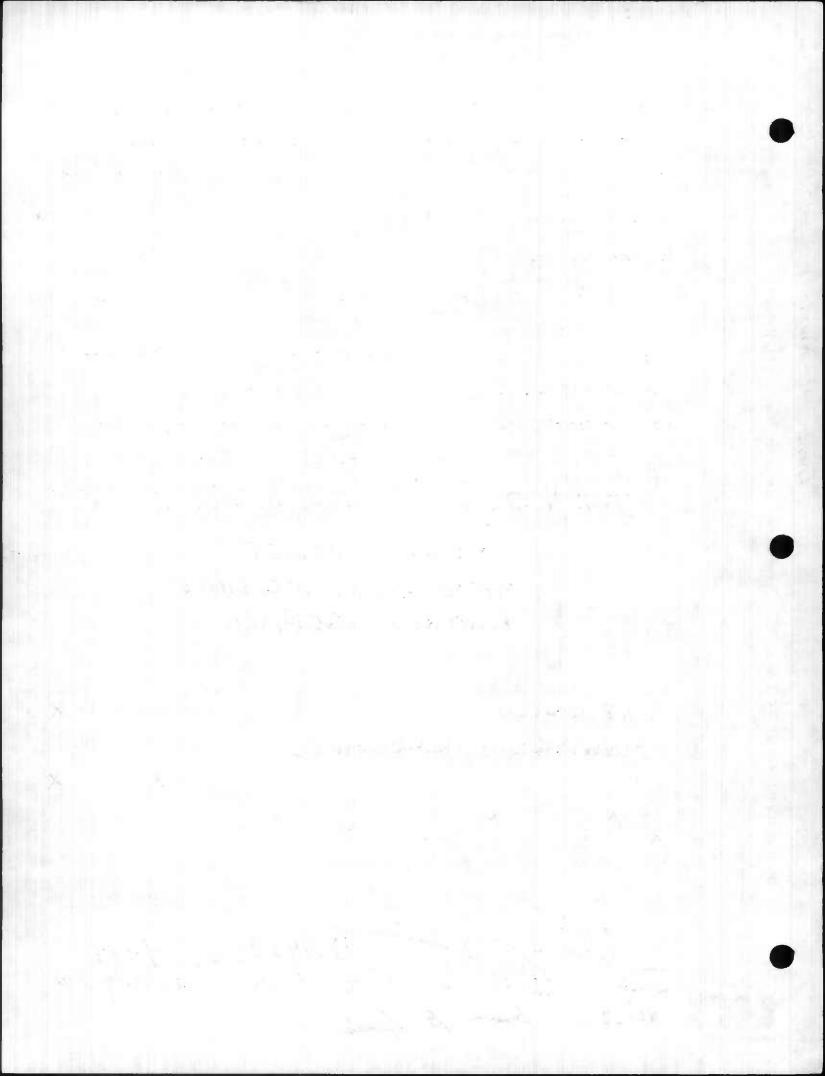
Physician /Medical Examiner		ne (First, Middle, Last)		00/11/00	ate of	Dodan	2. Date of De			Time of Death	
Examiner	James	Anthony			Moo	re	Month May 11	Dey 1, 1999	Year	3:30 AM	
	4a Facility Name (If not institution, gir					4b. City, Town, or				S:30 AM	
Funeral	Salisbury Center		FldorCa	ro		Salisbur	~ MD	Wico	mico		
Tullerat			(In yrs. last bi	rthday) If Un	der 1 Year	If Under 24 Hrs	8. Dete of Bir			(State or Foreign	
Director	144-32-3247 Usual Residence of Decedent	1⊠M 2□F {	36	Yrs. Month	ns Days	Hours Min		er 27,1912	Scott		
* W	10a. Sfata 10b. County		10c. City, Tow	m or Location					10d. I	nside City Limits	
o de	Maryland Wicon	nico	White	ehaven					1	☐ Yes 210 No	
100	10e. Street and Number			10f.	Zip Code			10g. Citizen of V	Vhaf Country?		
23 E	2734 Whitehaven	Rd.			2185	6		USA			
natural, or items 23a or 28a-f ahow	11. Meritel Status  1 Never Married 2 Merried 3 XWidowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:			cedent of H pecify Cubi	lispanic Origin? (San, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Race Blac Specify	e - American Ir ek, White, etc.		
te pet	15. Decedent's E	ducation	16a	. Decedent's U	sual Occup	ation	4.5-0	16b. Kind of Bu	usiness/Industr	у	
	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5	+)	life. DO NOT	use retired	during most of wo d)	orking				
Hygiene. ther then mt, the te	12		Pı	ofessi	onal	Gardner		Garder	ning		
Tto al	17. Father's Name (First, Middle, Last				_	18. Mother's Ne	me (First, Middle	, Meiden Sumem	ie)		
leith and Mental 127 la marked of traumatic aver To Bo	Robert Thomas Mo	ore				Anne	McGuirk				
and man	19a. Informent's Neme/Relationship							er, City or Town,		le)	
27 er tr	James Moore Jr.,	/Son				ven Rd.,	Whiteha	iven, MD	21856		
nt: If lien	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Demoual from State	20b. Place o	of Disposition (f ory, crematory of	Vame of or other place	ce)	Dete	20c. Location -	City or Town,	State	
Int. II	4 Donation 5 Other (Special		Wicon	nico Mer	moria	l Park	5/14/99	Salis	sbury,	MD	
ing physician and ses the buriel-fransit aminer when the buriel-fransit aminer Medical Examiner	23a. Part1. Enter the disease, or comshock, or heart failure. List only finmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a b	Due to (or as a Due to (or as a Due to (or as a	consequence of	Age or):	Cor			1	y GRAM	
d by the attending etached for use a Physician/M	Part II. Other significant conditions of		ıt not resultina i	n the underlyin	a cause div	ren in Part I.	23b. Did	tobacco use cor	ntributa to the	cause of deat	
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od by								s an autopsy omed?	evailab	utopsy findings le prior to stion of cause h?	
as been s a 2 should npleted							10	Yes 2 No	1 ☐ Ye	s 20 No	
has pe 2		11 - 15 - 4			Lou		ath (Check only	one)			
ertificate has actor, page 2 Be Comp	25. Was case referred to medical examiner?	Hospitaf: 1   Inpatient 2   ER/Outpatient 3   DOA   Ot				4 Mursing	_	idence 6 Oth			
his certificate has al director, page 2 To Be Comp	examiner? 1 Yes 2 No	28a. Date of Injury (Month, Day Year)  28b. Time of Injury Injury			28c. Injui	y at k?	28d. Describe	ribe how injury occurred			
ath.  r: Aftar this certificate has the funeral director, page 2 atlon: To Be Comp	examiner? 1 Yes 2 No 27. Manna-of Death 1-Naturaf 5 Pending 2 Accident investigatio	28a. Date of Injui (Month, Da)				Yes 2□No		281. Location (Street and Number or Rural Route Number City or Town, State)			
err. r: After this certificate has te funeral director, page 2 atlon: To Be Comp	examiner? 1 Yes 2 No  27. Mannar of Death 1 Natural 5 Pending	28a. Date of Injur (Month, Da)	ry - At home, fa	fnjury M	10				er or Rural Ro	ute Number,	
ath. r: Aftar this certificate has te funeral director, page 2 atlon: To Be Comp	examiner? 1   Yes   2   No  27. Mannar of Death 1   Naturaf   2   Accident   3   Suicide   4   Homicide  29a. Certifier   1   Certifying Ph	28a. Date of Injur (Month, Da)	iry - At home, for a second of the second of	fnjury M arm, street, fact	tory, office	Yes 2 ☐ No	City or To	wn, State) cause(s) and ma	anner as atated	1.	
ath. r: Ahar this certificate has the funeral director, page 2 atlon: To Be Comp	examiner?  1 Yes 2 No  27. Manna-ef Death  1-/ Naturaf 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only 2 Medical Examiner)	28a. Date of Injur (Month, Da)  28e. Place of Injur building, etc.  28e. Place of Injurbuilding, etc.	iry - At home, for a second of the second of	Injury M arm, street, fact e, death occurred/or investigati	tory, office	Yes 2 No	City or To	wn, State) cause(s) and ma	anner as atated and dua to the	i. cause(s)	
ath. r: Affar this certificate has the funeral director, page 2 atlon: To Be Comp	examiner? 1 Yes 2 No  27. Manna-ef Death 1-Naturaf 5 Pending investigatio 3 Suicide 6 Could not be determined.  29a. Certifier (Check only one)  1 Yes 2 No  2 Pending investigation determined.	28a. Date of Injur (Month, Da)  28e. Place of Injur building, etc.  28e. Place of Injurbuilding, etc.	iry - At home, for a second of the second of	Injury M arm, street, fact e, death occurred/or investigati	1 dory, office ed at the tirion, in my co	Yes 2 □ No  me, date end placepinion, deeth occurs enumber	e, and due to the urred at the time,	cause(s) and ma date and place, i	anner as atated and due to the d (Month, Day,	i. cause(s)	
in 24 hours after death.  The Funeral Director: After this certificate has pletely filled in by the funeral director, page 2 edical Certification: To Be Comp	examiner? 1 Yes 2 No  27. Manna-ef Death 1-Naturaf 5 Pending investigatio 3 Suicide 6 Could not be determined.  29a. Certifier (Check only one)  1 Yes 2 No  2 Pending investigation determined.	28a. Date of Injur (Month, Da)  28e. Place of Injur building, etc.  28e. Place of Injurbuilding, etc.  28e. Place of Injurbuilding, etc.  28e. Place of Injurbuilding, etc.	iy - At home, fi (Specify) I my knowledge examination ar	Injury M arm, street, fact e, death occurr d/or investigati	1 dory, office ed at the tirion, in my co	Yes 2 No	e, and due to the urred at the time,	cause(s) and ma date and place,	anner as atated and due to the d (Month, Day,	i. cause(s)	

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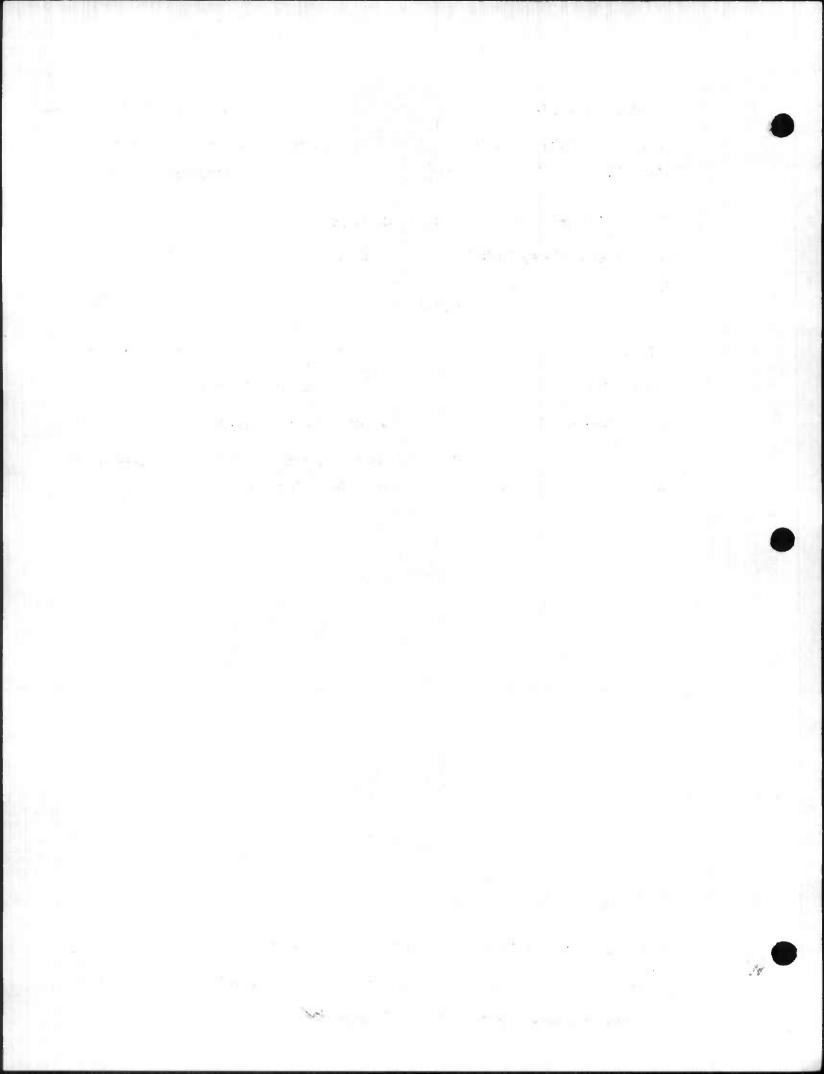
# 213-14-1225 JAMES H. MURREIL

					Ce	rtificate	e of	Death			Reg. No.			
sician	1. Decedent's Neme (First, Mi JAMES	iddle, Last)	HOWA	DD.		MIIDD				2. Date of De	Dey		rear	3. Time of Death
cal	4a Facility Name (If not institu	ution, give st				MURR			wn, or Lo	cation of Deat	11 th 4c.0	County of	99 Deeth	4440
ner	PENINSULA REG				ER				ISBU			WICO		
	5. Sociel Security Number 213–14–1225		M 2□ F	7. Aga (In yrs. 76	last birthday, Yrs.	If Under   Months	1 Yeer Deys	If Under Hours	24 Hrs. Min.	8. Dete of Bir (Month, De June	ey, Year)	_	9. Birthple Count Mary	
ō	Usuel Residence of Decedent 10e. Stete 10b. Cou Maryland Wi		20		y, Town or L Salish								10	d. Inside City Lim
	10e. Street and Number					10f. Zip	Code				10g. Citiz	zen of Wh	nat Count	ry?
3	104 Roseberry	y Ave.					218	304				USA		
	11. Marital Status  1 Never Married 2 N	Married	Armed For 1 X Yes If Yes, Giv	2 No AirFor		Was Deced If Yes, spec				ecify Yas or No Rican, etc.)		I4. Race Bleck, Specify:	White, e	tc.
	3 Widowad 4 Divord	dent's Educi	Yaar or Da	atas: WW I		edent's Usue	al Occur	ation				nd of Busi		
Completed	(Specify only hig Elementery/Secondary (0-1:	ghest grade	completed) Coilege (1	-4or 5+)	(Give	DO NOT us	rk done se retired	du <i>ning m</i> os d)	t of work	ing		ectri		
	17. Father's Neme (First, Midd	17. Father's Neme (First, Middle, Last) Howard Edward Murrell				Systems Operator  18. Mother's Neme (First,					, Malden S	Su <i>ma</i> me,	)	
٦ efc	Howard Edward Murrell						Frances E. Parke							
	19e. Informent's Name/Reletion									el Route Numb				
	Elizabeth Mur 20e. Method of Disposition	rrell/	Wife	20b. P	leca of Disp	osition (Nen	ne of		ve.,	Salisb		MD 2		
	1 Buriel 2 Cremetic		moval from S	Stata	emetery, cre	metory or o	ther plea		5	/12/99		isbu		
	Signature of Aumeral Security     Security	91	1 Dom	MOIC	) SI H	01 Sn	ay F	unera	al Ho	Salisb	urv.		1804	Approximate
i	shock, or heert feilure. List only one ceuse on each line.										Interval Between			
ician dical niner	Immediate Cause (Finel disease or condition resulting in death)  a. CANDIAC ARREST  30 M41  Due to (or as a consequence of):  SUBARBEHNOD HEMORRITAGE													Interval Between Onset and Deeth
er	disaase or condition	a.	9		DIAC					-				Onset and Deeth
amlner	disaase or condition	a.	Su	Due to (o	DIAC	equence of):	AF	ere M	ST OP	eita G				Onset and Deeth
M	disaase or condition resulting in death)	a. b. c.	Su	Due to (or Due to (or MAN)	OTAC or as e conse  BCHA or as a conse	induence of):	AF		ST OP	eita G				Onset and Deeth
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by Physician/Medical Ex	disasse or condition resulting in death)  Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest	a.  b. c. difficulty contractions contractio	R R	Due to (o	or as e conse BHA or as a conse CLD or es a conse	equence of):	Af H N	ERE SUR	35 061 481	23b. Did	SE I tobacco o	□ No :	ribute to 3 Prob	Onset and Deeth  30 MW
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State of Maryland / Department of Health and Mental Hygiene

						*			Death	i wellai n	Reg. No.	9 ]	72	80.
Phys	ician	_	<ol> <li>Decedent's Neme (First, Middle, Li</li> </ol>							2. Dete of D Month	Peeth Dey	Year		e of Death
	dical		Robert Kent Mite							May		999	17	=02
Exam	niner	ľ	te. Facility Neme (If not institution, gi	ve street end number,	)				4b. City, Town, o	or Location of Dee	eth 4c. Cour	nty of Deeth		
		۹.	933 Pulaski High							e Grace				
Funer Direct				Sex 7. And 10X M 2□ F	ge (In yrs. les	t birthday) Yrs.	If Under	Deys	If Under 24 H Hours M	8. Date of E (Month, I 03/14	f Birth , Dey, Year) 4/1918 9. Birthplece (Stete or For Country) MD			ete or Foreign
death with the Manyland rms 23a or 28a-f show	5		10a. Stete 10b. County			Town or Loc								le City Limits
Ne W	act c	-	MD Harford		Ha	vre d								165 2 110
E 0 8	ä	5	10e. Street end Number				10f. Zip				10g. Citizen o	f Whet Cou	ntry?	
e 23	E S	3	933 Pulaski High		***	140.11	210			10 11	USA			
_ is 2 2	by Funeral Director		11. Meritel Stetus  1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Armed Forces' 1 DYes 2 If Yes, Give Yeer or Detes:	? No	1	Yes, speci		Specify:	(Specify Yes or Nerto Rican, etc.)	Spec	ece - Ameri leck, White, cify: Whi	etc.	n,
72 hours	20	-	15. Decedent's E	ducation		16a. Decede	ent'e Usuel	Occup	etion		16b. Kind of			
within within then	Completed		(Specify only highest gr Elementery/Secondery (0-12) 11th	ade completed) College (1-4or		(Give k	ainte	k done e retired	during most of v	vorking	Self-E			
filed thygin			17. Fether's Neme (First, Middle, Las	t)					18. Mother's N	eme (First, Midd				
Maryland d 2 should be file th and Mantal Hy 7 Is marked othe traumetic svant.	To Be		George Mitchell						Evelyr	Jackso	n			
aryla 2 should and Man 1s marks	1		19e. informent'a Neme/Reletionship	(Type, Print)		19b. Meiling	Address	(Street		Rural Route Num		m, Stete, Zij	o Code)	
and 2 saith ar n 27 is er trau			Jack Mitchell-Br	other	1	04 Ba	vlan	d D	r #5	Havre d	e Grace	MD	210	78
Baltimore, N pemit. Pages I and Department of Health Important: If item 27 any Injury or other tr		1	20e. Method of Disposition		20b. Pled	a of Dispos	Ition (Nem	e of		Dete	20c. Location			
Pages nent of mrt: If its iry or o			1 Burial 2 ACremetion 3 5			etery, crem	•		,	F /11 /00	W C	da a a ta		
Daltim pemit. Pag Department Important: N any Injury o		H	21. Signeture of Funerel Service Lice		K.A.				. Inc.	5/11/99	West C	neste	r, P	A
Demit. Departr	Buce		23e. Fast. Enter the disease, or con	1 50	Abri	Mi	itchel	II-S	mith Fu	neral Ho	ome, P.	A. ace. N	/D 2	1078
			23e. Part. Enter the diseese, or con shock, or heert feilure. List only	nplicetions thet cause one cause on each I	d the death.	Do not ente	r the mode	of dylr	ng, such es card	iec or respiretory	arrest,		Interval	Between
Physicia /Medica	_		Immediete Cause (Finel diseese or condition		Asm	115						İ	Onset a	ind Deeth
Examine	er	ı	resulting in deeth)	θ	Due to (or e		ience off.							
	je je				20010101010	o a consequ	101100 017.					1		
.U. BOX 68/6U, the death certificate be executed y the attending physician and tohed for use as the burial-transit	Examiner		Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	b. ————	Due to (or e	s a consequ	ience of):							
68760, tificate be exerging physician east the burial-	fedical		Cause (Disease or Injury that initiated events resulting In death) Last	c	Due to (or es	e consequ	ence of):					-		
box box based death certifical attending ph	Sugar Sugar			d							·	1		
the att	sici	ī	Pert il. Other significant conditions	contributing to death b	out not resulting	ng in the und	derlying ca	use giv	en in Pert I.	23b. Di	d tobacco use	contribute t	o the cau	se of death
7 # # # # # # # # # # # # # # # # # # #	by Physician/N		-							10	Yes 2 No	3 □ Pro	bably	4 🗆 Unknow
aw requires the second as been second 2 should	Completed k	-								24a. Wa	is en autopsy formed?	8/	allable p	osy findinga rior to of cause
The The page	0									10	Yes 2□No	11	☐ Yes	2□ No
	Be		25. Wes case referred to medical examiner?						26. Place of D	eath (Check only	one)			
	To		1 Yes 2 No	Hospitel: 1 ☐ Inpatio	ent 2 EF	VOutpetlent	3 DO	A Oth	er: 4 Nursing	Home 5 Re	sidence 6 🗆 C	ther (Speci	fy)	
tarth the			27. Menner of Deeth 1 ⊠Netural 5 □ Pending	28a. Dete of Inju (Month, De	ury 28	3b. Time of Injury	28	c. Injur Wor	yet ~A	28d. Describe	how injury occ	urred		
ath. At: At	atic		2 ☐ Accident investigetio	n NA	,,,,,,	NA	М		Yes 2 □ No	1	JA			
To the Hospital or Attending Is within 24 hours after death. To the Funeral Director: Atter completely filled in by the luner	Certification:	3   Suicide 6   Could not be determined 28e. Pleca of Injury - At home, ferm, street, fectory building, etc. (Specify)										Vumber,		
24 hour 24 hour Funera	edicai (		29e. Certifler  (Check only 20 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and menner as stated.  20 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and menner as stated.										se(a)	
o the	×							Licens	e number		29d. Dete eig	ned (Month,	Dey, Ye	ar)
- 3 - 0			Maria A.		0	ME		_	CME			1-10	9 4 6	
1		-	O Name ded address of	completed or			(cine)	0	CME		2 -	1-10	777	
		(	O Name and eddress of person who		FU L			46	SEL	Ann	MD 2	101	1	
Regi	strar	3	31. Pete filed (Month, Dey, Year)		rer's Signetur		10	A 4						



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** Month Vaar May 1999 10 = 12 AM Ralph Allen Mitchem 8 /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 100 Gracecroft Drive Havre de Grace Harford 5. Social Sacurity Number If Undar 1 Year If Undar 24 Hrs.

Months Days Hours Min. 8. Data of Birth (Month, Day, Year) 03/03/1938 9. Birthplaca (Stata or Foraign Country) West Virginia 7. Aga (In yrs. last birthday) **Funeral** 1**™** M 2□ F Yrs Director 61 225-50-6223 Usual Rasidance of Dacedani permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Meryland Department of Heelih and Meniel Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, in Medical Examinat must be notified at once. 10a Stata 10b. County 10c. City, Town or Location 10d. inslda City Limits 1 X Yas 2 □ No Directo Harford Havre de Grace 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 100 Gracecroft Drive 21078 USA Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 14. Race - Amarican Indian, Black, Whita, atc. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 Nevar Married 2 Married 1 ☐ Yas 2 X No If Yas, Giva Yaar or Datas: Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: þ Specify: White 3 Widowed 4 Divorced 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) Collaga (1-4or 5+) 4th Street Maintenance Dept. of Public Works 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Isaac Andrew Mitchem Winnie Ann Stoots 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Eugene Mitchem- Brother Rt. 4 Box 416 North Tazewell, VA 20b. Piace of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data 1 X Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Angel Hill Cemetery 5/13/99 Havre de Grace, MD 21. Signature of Funaral Sarvice Licensee 22. Nama and Addrass of Facility Mitchell-Smith Funeral Home, P.A. 123 S. Washington St., Havre de Grace, MD 23. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, mock, or heart failure. List only one cause on each line. Approximata interval Between Onsat and Death **Physician** /Medical Immediata Causa (Final diseasa or condition rasulting In death) ASCVO Examiner Due to (or as a consequence of) Examiner MERLITUS DIABETES physician and the burial-trensit law requires that the death certificata be executed Sequantially list conditions, if any, laading to immadiata cause. Entar Undarfying Causa (Disease or Injury that initiated evants rasulting in daath) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequance of): 80 080 signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 | Yas 2 | No 3 | Probably 4 | Unknown HYPERTENSION by 24b. Wara autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed Colon Conces certificate has 1 Yas 2 No 1 Yas 2 No director, 25. Was casa rafarrad to medical axaminar? Be 26. Placa of Death (Check only ona) Hospital: Othar: 4 ☐ Nursing Homa 5 ☑ Rasidence 6 ☐ Othar (Specify) 1 Yas 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Data of Injury (Month, Day Year) 27 Mannar of Death 28b. Tima of Injury 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: 1 Natural 5 Panding invastigation or Attending safter death. 1 Yas 2 No NA 2 Accidant NA NA 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 6 Could not be datamined 3 ☐ Suicida 28a. Place of injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida A 24 hour. Hospital 24 hours a 29a. Certifiar (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. To the I within 2 29b. Signatura and titla of certified 29d. Data signed (Month, Day, Year) 5.8.1999 DME OCME 30. Name and addrass of person who complated causa of death (Itam 23a) (Type, Print) NA BHO 218 FULFOND AVE BELAN MD 21014 31. Data filad (Month, Day, Year) 32. Registrar's Signatura

Registrar

4. . . . . . . . 

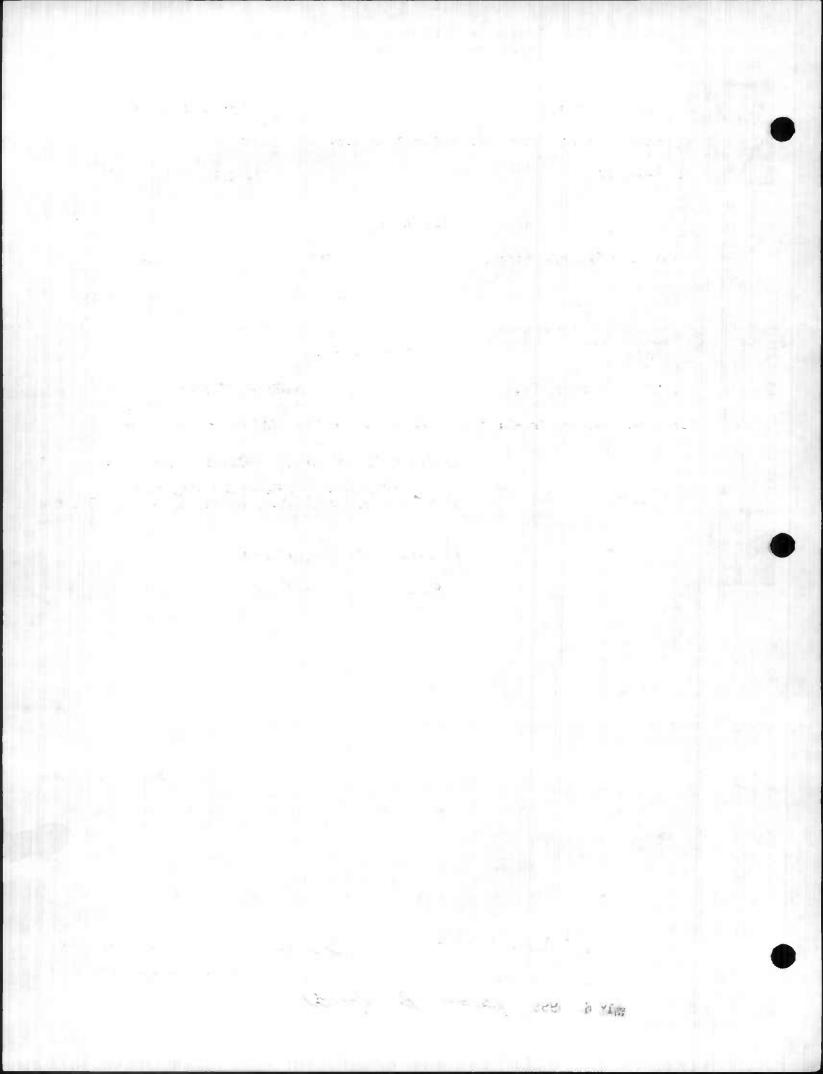
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey Month Yee **Physician** 1999 James Robert Meager 30, 1730 April /Medical 4e Fecility Neme (If not Institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** CenterBaltimore of Maryland Medical University If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (in yrs. last birthdey) Birthpiece (Stete or Foreign Country) 8. Dete of Birth (Month, Dey, Year) **Funeral** 1XM 2□ F Months Deys **Director** 218-76-5497 58 MD 4/16/1941 Usuel Residence of Decedent with the Maryland 10e. Stete 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or flema 23a or 28a-f ahow other traumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Director MD Baltimore 10e. Street end Number 10a, Citizen of Whet Country? 10f. Zip Code 501 West Franklin Street Funeral 21201 deeth 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. permit. Peges 1 and 2 should be filed within 72 hours effer of Department of Heelih and Mentel Hygiene. Important: if Item 27 is marked other than "natural", or item any injury or other traumetic event, the Medical Essentiand. Yes 20XNo 1 Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: by Specify: White If Yes, Give Yeer or Detes: 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) n/a Never worked 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) John H. Meager, Sr. P Nellie M. Fantom 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) John H. Meager, Jr.-Brother 303 Overview Dr., Abingdon, MD 21009 20b. Place of Disposition (Name of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stete Date 1 XBurial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wesleyan Chapel Cem. 5/6/99 Havre de Grace, MD 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Mitchell-Smith Funeral Home, P.A. 23e. Rant Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest,

Approximate Approximate Intervei Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Final diseese or condition resulting in death) DIRATION **Examiner** Examiner Respirator that the deeth certificate be executed ettending physician and for use es the buriel-trans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es consequence of) Box 68760. Physician/Medicai Due to (or es e consequenca of): P.0. Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detac 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, þ 24b. Were autopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed hes 1 ☐ Yes 2 No 1 ☐ Yes 2 No certificete Hospital or Attending Physician: funeral director, 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Hospitei: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2. ER/Outpatient 3□ DOA Certification: To this 28e. Dete of injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of 28c. injury at Work? After? 1 Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours efter deeth.

Funeral Director: Al 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 - Homicide Medical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end piece, end due to the ceuse(s) and menner es stated. completely (Check only one) 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and piece, and due to the cause(s) end menner steted. To the Youth 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signeture end title of cartifile hours tos D32700 1999 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) ANWAR KHOREHAR MO Relt ho was 821 NONTH EUTAW ST Smite #103

State Registrar 31. Dete filed (Month, Dey, Year)

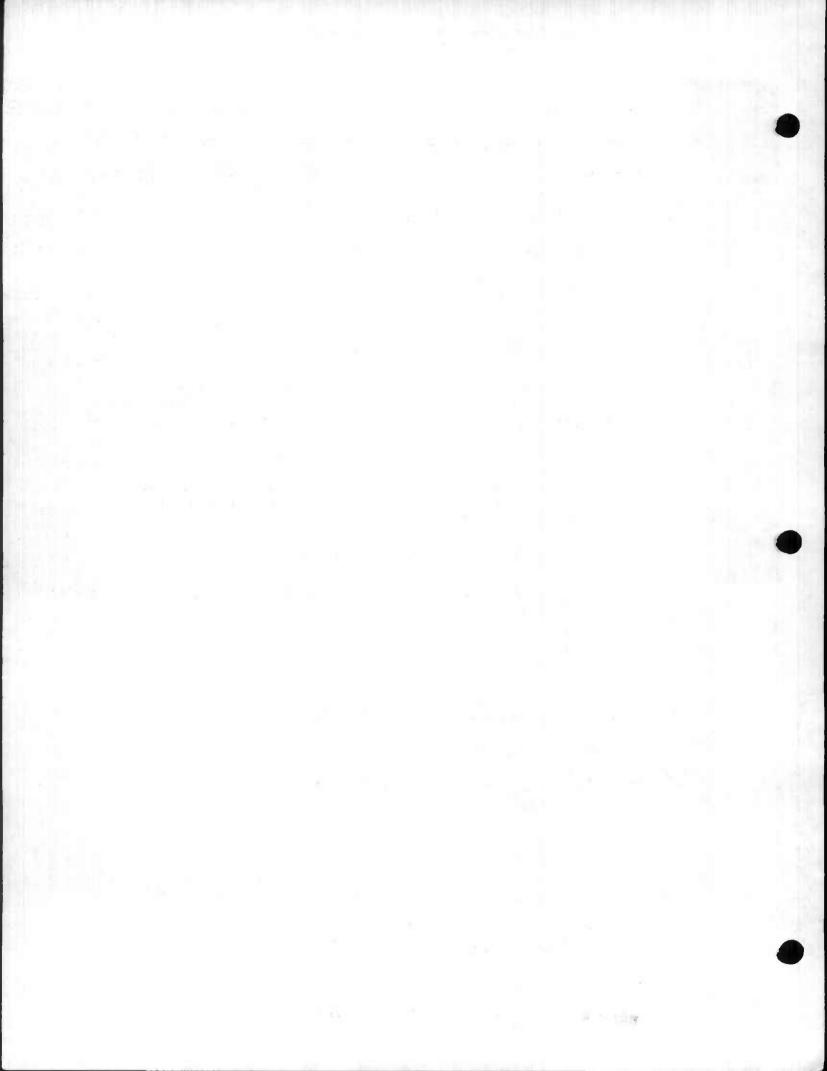
32. Segistrar's Signature



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** Einer Madsen /Medical 4e. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NURSIN9 HAUre De GRACE HARSORD TOME Zeins 8. Deta of Birth (Month, Day, Year) If Under 1 Undar 24 Hrs. 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) Birthpleca (Stata or Foraign Country) **Funeral** 1 M 2□ F Yrs 078-07-0253 Director Denmark Usual Rasidance of Decedant the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits item 27 is marked other than "natural", or itema 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at Maryland Harford Aberdeen 1⊠ Yes 2□ No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 670 Andrews Road 21001 U.S.A. Funeral 11. Maritel Status 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puarto Ricen, etc.) Rece - American Indien, Black, Whita, etc. 72 hours efter 1 ☐ Yas 2 🔀 No If Yas, Giva Yeer or Datas: 1 Nevar Married 2 Married "natural", or Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☒ No p Specify: White 3 ₩ Widowed 4 Divorced Completed 16e. Decedant's Usuat Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Spacify only highest grada complated) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within. Depertment of Heelth end Mental Hygiene. Important: If Item 27 Is marked other than "nany Injury or other traumatic event Elementery/Secondary (0-12) Collaga (1-4or 5+) Laborer Carpenter 8 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Christine Pedersen Martin F. Madsen 19a. tnformant's Name/Retetionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 670 Andrews Rd., Aberdeen, Maryland 21001 Peggy Dymond (Daughter) 20b. Ptace of Disposition (Nama of cemetary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) R. A. Ferris & Co., Inc. 5/15/99 West Chester, PA 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Fecility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that ceused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Physician /Medical Immediate Cause (Final diseasa or condition rasulting in daath) Examiner the buriel-transit Sequentially list conditions, if any, leeding to Immadiate ceusa. Entar Undarlying Causa (Disaasa or Injury that Initiated events rasulting in deeth) Lest Dua to (or as a consequence of Records, P.O. Box 68760 physician Physician/Medical Due to (or as a consequance of): attending Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributa to the cause of death? signed by I 1 Yas 2 No 3 Probably 4 Unknown by 24a. Was an autopsy performed? 24b. Were eutopsy findings available prior to completion of ceuse of death? Be Completed has this certificate 2 NO 1 Yas 2 No 4145 25. Was case rafarrad to pa director. 26. Pleca of Daath (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Mennar of Death 28e. Deta of tnjury (Month, Day Year) 28b. Tima of 28d. Describe how Injury occurred Medical Certification: 28c. Injury at Work? After 5 Pending Investigation 1 Naturat 1 ☐ Yas 2 ☐ No death. 2 Accident Director: in by the 6 Could not be detarmined 3 Sulcida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Plece of Injury - At home, farm, streat, factory, office building, atc. (Specify) 4 Homicida Hospital or To the Hospital within 24 hours a To the Funeral C completely filled Land Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceusa(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceusa(s) and manner stated. 29a, Certifian 29b. Signeture end title of cert 29c. License number 29d. Deta signed (Month, Day, Year) 10 30. Neme end eddrass of person who completed ceuse of deeth (Item 23a) (Type, Print) MAHUE 31. Data fited (Month, Day, Year) 32. Registrar's State Registrar MAY 1 8 1555



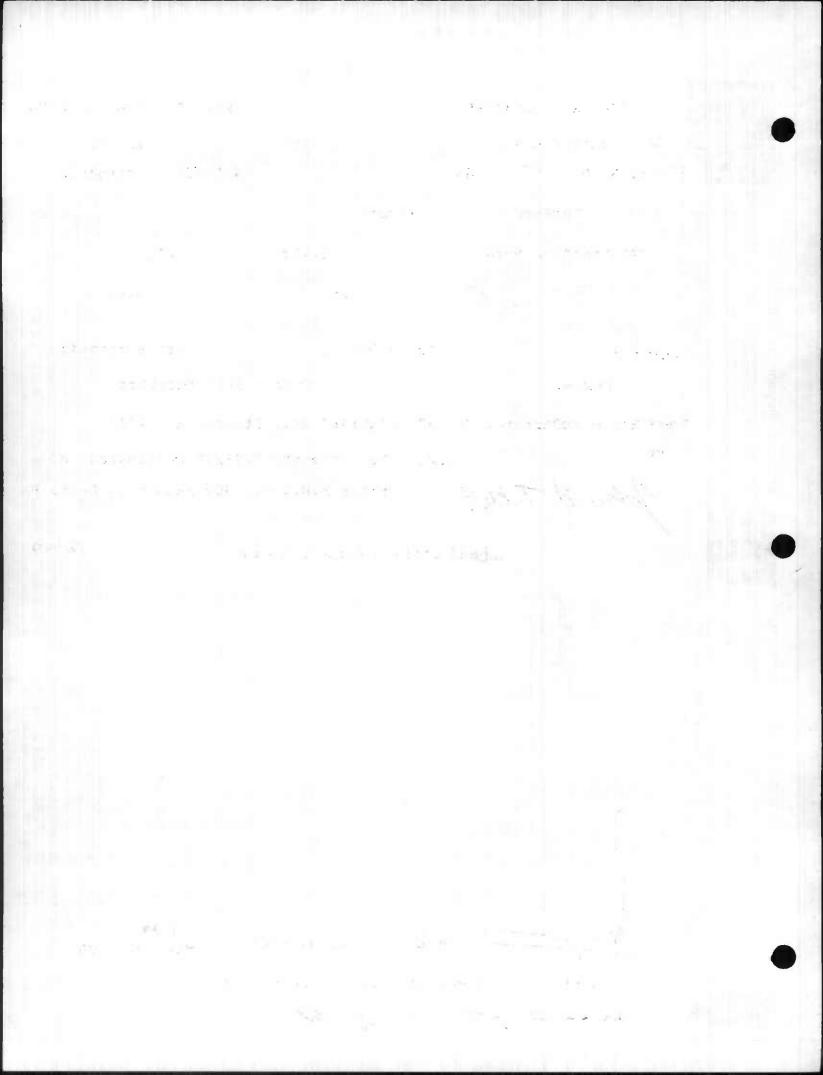
			State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. No.
	Physic /Medi		1. Decedant's Nama (First, Middla, Last)  Robert , Mason Jr.  2. Data of Death Month Month May 14, 1999 0745
	Examir		4a. Facility Nama (If not Institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
	Director		219427540 12M 2DF 53 Yrs. Months Days Hours Min. Aug 19,1945 Country) MD  Usual Residence of Decedant  10a. Stata 10b. County 10c. City, Town or Location 10d. inside City Limits
	hours after death with the Maryland urat', or flems 23a or 28a-f show at Examines must be notified at	<b>Funeral Director</b>	MD Harford Havrede Grace 109 Yas 2 No  10e. Street and Number 10f. Zip Code 10g. Citizan of What Country?  915 E1; 2ab of k 5f 2107 8  11. Marital Status 12. Was Decedant Evar In U.S. 13. Was Decedant of Hispanic Origin? (Specify Yas or No- 14. Race - American Indian,
-0020	172 hours after dea "netural", or items	ed by Fur	Amed Forces?  1 Navar Marriad 2 Married  3 Widowed 4 Divorced  Amed Forces?  If Yas, specify Cuban, Maxican, Puarto Rican, atc.)  If Yas, Specify:  Black, Whita, atc.  1 Yas 2 No Specify:  Specify: Black, Whita, atc.
21215-0020		Completed by	15. Decedant's Education (Specify only highast grada complated)  Elemantary/Secondary (0-12)  16a. Decedant's Usual Occupation (Giva kind of work don a during most of working life. DO NOT use ratired)  5 igual Repair  Refused  16b. Kind of Businass/Industry
Maryland	2 should be fill and Mental H is marked oth eumetic even	To Be	17. Father's Nama (First, Middla, Last)  18. Mothar's Nama (First, Middla, Maiden Sumama)  Robert Masan SL  19e. intorment'a Neme/Rejationship (Type, Print)  19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code)
-	other tr		Robert Mason TIT.  915 Elizabeth 5t Habre Jo Corace MD.  20a. Mathod of Disposition  10 Burial 2 Cramation 3 Ramovai from Stata  20b. Place of Disposition (Name of cematary, cramatory or other place)  20c. Location - Cify or Town, Stata
Baltimore	permit. Pege Department of Important: If any injury or once.	Q 1	21. Signatura of Funarai Sarvice Licensea  22. Nama and Address of Facility  BEARD FUN YOUR MONE  532 Lawis 54 Haure de Grady MD
	Physician /Medical Examiner		23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart tailura. List only ona cause on each line.  Approximate Interval Between Onset and Death
00,	icata be axecuted physician and s the burial-transit	I Examiner	Immediate Causa (Final disease or condition rasulting in death)  Dua to (or as a consequence of):  Human Immuno deficiency Vivus Infection  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):
Box 68760,		n/Medical	Cause (criseas of injury that initiated avants rasulting in death) Last  Dua to (or as a consequence of):  MAY 7
P.O.	es thet the death certificioned by the attending be detached for use a	by Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t.  End Stage Liver Discase  1 Yes 2 No 3 Probably 4 Unknown
Records,	s been s 2 should	Completed by	24a. Was an autopsy performed?  24b. Wara autopsy tindings availabla prior to complation of cause of death?
	The ate h		1 ☐ Yas 2 ☑ No 1 ☐ Yas 2 ☐ No 25. Was casa refaired to medical 26. Placa of Deeth (Check only one)
ion of Vital	ing Phys.  After this funeral di	tion: To Be	axaminar?    Town   Hospital:   See Injury
Division		Certification:	3 Suicida 6 Could not be datarmined 28e. Pleca of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28t. Location (Street and Number or Rural Routa Number. City or Town, State)
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Cartifiar  (Check only one)  15 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated.  2 Medical Examiner: On tha basis of examination end/or invastigation, in my opinion, death occurred at tha tima, data and place, and due to the cause(s) and mannar stated.
	with To	M	29b. Signatura and titla of certifiar  P12381  May 14, 1999
	25		30. Name and eddrass of person who completed cause of death (itam 23a) (Type, Print)  Alexancler Chuchnovsky, M.D. BVAMC 10N. Greene St. Baltimore, MD 21209  31. Data tiled (Month, Day, Year)  32. Registrar's Signatura
	Sta Registr		5. Data they (worth, Day, real)

from I love

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State of Maryland / Department of Health and Mental Hygiene

				Certificate of	f Death	Re	g. No.		203
		1. Decedent's Name (First, Middle, Las	t)			2. Date of Death Month	Day	Yeer 3	. Time of Death
	Physician /Medical	BERNARD	MCCARTER			May 1			:30 PM
	Examiner	4e Facility Name (If not institution, give	street and number)		4b. City, Town, or Lo	ocation of Death	4c. County	of Death	
		722 Highland	Road		Street		На	rford	
	Funeral Director	5. Social Security Number 6. Sr 218-28-3939  Usuel Residence of Decedent	7. Age (In yrs	S. lest birthdey) If Under 1 Yes Months Day		6. Dete of Birth (Month, Day, 4/16/3	Year)	9. Birthplace Country) Virgi	
	Pue A	10a. State 10b. County	10c. C	City, Town or Location				10d.	Inside City Limits
	vith the Meryl or 28e-f she be notified	MD Harf	ord	Street		10	a. Citizen of W		1 ☐ Yes 2000
	eth with the same or s	722 Highlan			21154		USA		
21215-0020	72 hours efter deeth with the Maryland natural; or Items 23a or 28a-f show doel Examiner must be notified at steed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 ☐ You If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Cu	f Hispenic Origin? (Spuban, Mexican, Puerto o Specify:	ecity Yes or No- Rican, etc.)		e - American I k, White, etc. ite	molan,
5-0	ed within 72 hours ygiene. er then "neturel", f. im Hede Ex.	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Decedent's Usual Occ (Give kind of work don life. DO NOT use reti	upation e during most of work	ing 1	6b. Kind of Bu	siness/Indust	lry
121	s within r than r than r	Elementary/Secondary (0-12)	College (1-4or 5+)	Truck Drive			Trans	norta	tion
7	other the Co			II UCK DIIVE	7	e (First, Middle, M			CIOII
Maryland	Se se se	TT 1				Bell M			
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Ma	2 0 0 0	19a. tnforment's Name/Relationship (7		19b. Meiling Address (Stre					00)
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Baltimore,	ages ant of t: If it y or o	Buriel 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	cemetery, cremetory or other parlington Ce					
Ball	permit. Pag Department Important: eny injury once.	21. Signature of Funeral Service Licens	Tellett	22. Name and Add		, 600 M	ain S	t., D	
	No. of Lot	231 Part. Enter the disease, or comp	olications that caused the decore cause on each line.	ath. Do not enter the mode of d	ying, such as cardiac	or respiratory arre	st,	Ap	proximate erval Between
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	Examiner	resulting in death)	Due to	(or es e consequence of):				1	
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oʻ	physician end s the buriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to	(or es a consequence of):					
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State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene

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/Medical Examiner	4e Facility Nama (If not institution, g Civista Medical					om, or Location of		4c. County		0.52 F.M.
Funeral Director	5. Social Sacurity Number 162–38–5881 6.	Sex 1∭ M 2□ F 49	yrs. last birthda Yrs.	y) If Under 1 Year Months Days	If Under		of Birth	<b>1</b> 950	9. Birthpl NOT L	laca (Stata or Foreign A) Carolina
death with the Maryland rms 23e or 28e-1 show r.mast be notified at neral Director	Usual Rasidance of Decedant  10a. State 10b. County  Maryland Prince (		c. City, Town or Suit	Localion					10	0d. Inside City Limits 1 ☐ Yas 2 ☑ No
th with the Ma 23e or 28e-fi unt be notified		arkway #205		10f. Zip Code 2074	6			Citizen of V J.S.A		lry?
10 Mag 10	3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Ever Armed Forcas? 1 No as 2 No If Yas, Giva Yaar or Dalas:	1969- 1989	Wes Decedent of I If Yas, specify Cub	dispanic Ori an, Mexican Specify:	gin? (Specify Yes , Puerto Rican, et	or No- c.)	Biad	e - America ck, Whita, a	alc.
ed within 72 ho ygiene. or than 'natur. f. the Medical.	15. Decedent's l (Specify only highest g	Education rade complated)	(Giv	edent's Usual Occup ka kind of work done DO NOT use retire	during most	of working	16b.	. Kind of Bu	usinass/Ind	lustry
tal Hyginad dother event, It	17. Fathar's Nama (First, Middla, Las			unication	S 18. Mothe	r's Nama (First, M	fiddle, Maid	len Sumam		rce Ret.
and Men and Men amende summile To	Harrison Mood  19a. Informant's Name/Ralationship	4	19b. Ma	iling Address (Street		argie or or Rural Route		Lford by or Town,	Stata, Zip	Code)
CTNL	Edith C. Moody			8 Regency						
emit. Pages 1 a bepartment of Hea mportant: if Item ny injury or othe tips.	20e. Malhod of Disposition  1 Description 2 Cramation 3 4 Donation 5 Other (Special Control of Cont	Ramoval from Stata	Marylan	rematory or other pla ad State V	eterar	is Cem.			nham,	Maryland
permit. Depart Import any inj ance.	21. Signature of Funaral Sarvice Lice	onsee		22. Nama and Address 6633 Old						on, MD20735
deeth cartificate be executed the attending physician and address the bunial-transit sician/Medical Examiner	Cause (Disaase or injury that initiated evants rasulting in daath) Last	c	to (or as a consi	equence of):	3					
d by the	Part II. Other significant conditions	contributing to death but no	ol rasulting in tha	underlying causa gi	ven in Part I	231	Did tobac	_	ntributs to	the cause of death?
aw requires to be a signification of the signification of the signification of the signification of the signification of the signification of the signification of the signification of the signification of the signification of the signification of the signification of the signification of the signification of the significant of the sig						24a	. Was an au performed		ava	ara autopsy findings allable prior to mpletion of cause death?
ician: The I certificate hi rector, page	25. Was casa rafarred to medical				00.01	15 11 101 1	1 Yas	2 No	172	JYas 2□ No
Physician: this certific ral director,	axaminar? 1 ☑ Yas 2 ☐ No	Hospital:	Ž(☐ ER/Outpati	ent 3 DOA Ot	her	of Death (Check		6 □Oth	ar (Specif)	()
tal or Attending as after death. at Director: After led in by the tune Certification	27. Mannar of Death 1 Natural 5 Pending 2 Accident invastigati 3 Suicida 6 Could not 4 Homicida	28a. Placa of Injury - building, atc. (S	ar) 28b. Tima Injury S - S At homa, farm, s	of 28c. Inju	nyat rk? ∣Yes 2 😭	No Mo	or Town, St	Le -	FYED	iver 1 object colly 11 Route Number, Rd
Hospi 4 hou Funer lely fill	29a. Certifiar (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place one)							e(s) and ma and place,	annar as st and due to	ated. tha cause(s)
To the To the Complet	29b. Signeture end tilla of certifier	46		29c. Licen.	se number C.M.E.			Dela signe May 10	21.041	The state of the s
10+1		wer		e, Print) 111 Penn	Stree	t, Balti	nore,	Mary.	land	21201
State Registrar	31. Data filed (Month, Dans)	8 1999 32. Registrar's 5	Signatura	B. Se	no de	/				

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State of Maryland / Department of Health and Mental Hygiene

				Ce	rtificate of	Death	Re	eg. No.		1.600
Physic /Med		1. Decedent's Nama (First, Middla, La Eva Inez Moore					2. Date of Daat Month 5	Day	Yaar 999	3. Tima of Death 5.457 M.
Exam		4a. Fecility Nema (If not institution, given 120 Clinton Str				4b. City, Town, or Lo	ocation of Death	4c. County Ceci		appro
Funera Directo	_	5. Social Security Number 6. S 212-22-5438 Usual Rasidance of Decedant	Sax 7. Ag	ga (In yrs. last birthday, 74 Yrs.	If Undar 1 Yaar Months Days		8. Dele of Birth (Month, Day, 02 25		9. Birthe	placa (State or Foreign http) yland
death with the Maryland ms 23a or 28a-f show		10a. Steta 10b. County		10c. City, Town or L	ocation				1	0d. Inside City Limits
sth with the Marylar 23e or 28e-f show	Director	Maryland Cecil		Elkton	10f. Zip Coda					1 □Xyas 2 □ No
3a or	ai Dir	120 Clinton St	reet		21921		10	0g. Citizan of V USA	vnat Cour	itry?
72 hours efter deat natural; or items 2	by Funeral	11. Marital Status  1 □ Navar Marriad 2 □ Married  3 □ Widowad 4 ☒ Divorced	12. Was Decedant Armed Forcas? 1 ☐ Yas 2 ☐ X If Yas, Giva Yeer or Datas:	N6		dispanic Origin? (Spen, Maxican, Puarto Specify:	ecify Yas or No- Rican, etc.)	14. Race	k, Whita,	
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d 2 should be file th and Mantal Hy 7 Is marked othe traumatic event,	Be	17. Fathar's Nama (First, Middla, Last)				18. Mothar's Name			a)	
hould d Man marke	2	Leonard Rudolph  19a. Informant's Name/Ralationship (		10h Maili	na Addrese /Street	Ella Re	ed Brown		State 7in	Codel
1 and 2 s Health an em 27 ls		Melisa R. Stewart			-	ntal Place				
60- 5		20a. Mathod of Disposition 1 ☑ 18urial 2 ☐ Cramation 3 ☐	Removal from State	20b. Place of Dispo cematary, cra	osition (Nama of matory or other pla	ce)	Data 2	20c. Location -	City or To	wn, Stata
Department mportant: If any injury o		4 Donation 5 Other (Specifical Service Lices	40-	-	e Methodd 2. Nama end Addra	Lst Cty.5/	/15/99 1 DNGO FUNI	Elkton,		yland
permit. Departr Importa		1 110119 1	TI MA	inal						
		23a. Part: Enter the disease, or dam	plicatory hat hause one cause on each is	the death. Do not an	OI NOTEN tar tha moda of dylr	Gray Ave.	or raspiratory arra	,DE 198 ist,	05	Approximata Intarvai Batween
Physician /Medical Examiner		The property of the party of th		e Myora Dua to (or as a conse	ordeal	Infarcti	on Sus	pecte	ed	
icata be axecuted physician and s tha burial-transit	i Examiner	Sequentielly list conditions, if eny, laeding to immediate causa. Entar Undarlying Causa (Disaasa or injury	b. H W	Dua to (or as a consecutive to (or a))).	quance of):					13 years
law requires that the death certificate be assocuted as been signed by the ettending physician and a should be deteched for use as the burial-transit	an/Medicai	Causa (Diseases of Injury that initiated avants rasulting in death) Last	d	Dua to (or es e consec	juanca of):					
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res that tha da signed by tha e	by	Exogeno	us o	hegy +	y		1 🗆 Ye			oably 4 Unknown
e law require has been si ge 2 should I	Completed						24a. Was an perform	n autopsy ned?	COI	ara autopsy findings ailabla prior to mplation of cause daath?
Physicien: The law requires the third care that cartificate has been signed and director, page 2 should be	8	25. Was casa rafarrad to medical				00 Diago of Dooth		s 20040	10	Yas 2□ No
ysic is ca direc	ToB	axaminer?	Hospital:	nt 2 ER/Outpatier	nt 3 DOA Oth	28. Place of Daath ear: 4 Nursing Ho	me 5 DR Rasida		er (Specifi	y)
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= 5 th 6	O	4 Homicida datarmined	building, et				28f. Location (Str. City or Town,	State)		
n 24 hours and Funerel I	ledicai	29a. Cartifiar 1 ☐ Certifying Phyone) 2 ☐ Medical Exam	raician: To the bast of iner: On the basis of and manner ste	of my knowledga, daath axamination and/or in ted.	n occurred et tha tin vastigation, in my o	na, data and place, a pinion, daath occurr	and dua to the ca ed at the time, da	usa(s) and mai ta and place, a	nnar as st and dua to	ated. tha causa(s)
To the within 2 To the comple	Me	29b. Signature and titla of certifiar	lal-KX	Petrimi)	29c. Licens	e number 2 2 3 0		d. Date signed	Month, I	Day, Year)
6		30. Nama and address of person who of 123 Singer	complated causa of d	eath (Itam 23a) (Type,	Driet	1, mo		21		
St	ate	31. Data filed (Month, Day Year)	32. Bagistra	ar's Senatura	edel			-		

YER LI YAN

asp	4 Deced-H- M	on (Florid Advider )			Cer	tificate of	De	eath	100000	Reg. No.	2	
Physician	1. Decedent's Nam		.ast)						2. Data of D Month MAY	-	999	3. Time of Death
/Medical	PETER A.											2316
Examiner	4a Facility Name (		ive street and number S HOSPITA					City, Town, or L HEVERLY			of Death	RGES
Funeral Director	5. Social Security N 219-49-0	The state of the s	Sex 7. 120 M 2□ F	Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days		lf Under 24 Hrs. Hours Min.	8. Data of Bi (Month, D	ay, Year)	9. Birthpla Country Kinust	ce (Stata or Foraign y) con, Jamaica
2	Usual Residence o											or y contract
T fine	10a. Stata	10b. County		10c. City, T	own or Lo	cation					100	d. Inside City Limits
death with the Maryand me 23e or 28e-f show Linust be notified at neral Director	Maryland	Prince	George's	Нуа	ttsv:	ille						1. Yas 2 No
6 2 2 2	10e. Street and Nu	mber				10f. Zip Code				10g. Citizen of	What Countr	y?
al mith	3350 Tole	edo Terra	ice, #H3			20	78	2		Jamai	ca	
3 28 5		ried 2 Married	12. Was Decede Armed Force 1 Yes 2 If Yes, Give	is?		Vas Decedent of Yes, specify Cut		panic Origin? (Specify:	pecify Yas or N D Rican, etc.)		ck, Whita, at	
0 20 0	3 Widowed	4 ☐ Divorced	Year or Date	<b>s</b> :		2 100 2 2 10		opeany.		Specin	B18	ack
ed within 72 hours at yglene. wr then "naturel", or t, the Medical Exam Completed by R	(Spec	15. Decedent's cify only highest g		1	6a. Deced	ent's Usual Occu kind of work done OO NOT use retire	upatio	on ring most of worl	king	16b. Kind of B	usiness/Indu	stry
with with	Elementary/Second 12th		College (1-4	or 5+)		Custodia				Dusi		
SEEF O	17. Father's Name		st)			ustoura	-	8. Mother's Nam	na (First, Middle	PT1 9, Maiden Suman	vate	
a sess		Notice	-7				"		Solomor		,	
To To	19a. Informant's N		(Tuna Print)		IDh Mailin	a Address (Street	of eac			l ber, City or Town,	Ctato Zin C	Pada)
04 母童語		Notice/										
1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and	20a. Method of Dis	<u>_</u>	WITE							e, Maryla		
Pages 1 a ment of Hea anti if Nem lary or othe	1X Burial 2	•	□Removal from Sta sify)	itet		sition (Name of natory or other pla orial Park		1	05/19 1999	Landove	19.00	
Depart Depart Import any in	21. Signature of Fu	Uneral Service Lio	2. Les	Lin	J.	Name and Addr B. JENKI 74 Lando	INS	5 FUNERA		ver, Mar	vland	20785
	23a. Part1. Enter t	the disease, or co	mplications that caus y one cause <i>on</i> eacl	sed tha death. (							. /	Approximata
Physician	snock, or nea	art tallura. List on	y one cause <i>on</i> each	n line.								ntarval Batween Onset and Death
the strate.	Immediata Cause	(Final	HUUT	2015 0	ALIN LI	- 1AD 14	M	)(				
Examiner	disease or condition resulting in death)	on	a. RUU	Due to (or as			0.7	3			1	
ž				Due to (or as	a conseq	pence orj.					1	
be executed sician and burial-transit	Sequentially list co if any, leading to in cause. Enter Under	onditions,	b	Due to (or as	a conseq	uence of):					U.	-0.5
burle	Cause (Disease or	injury	C									
2 22 2	that initiated event resulting in death)			Due to (or as	a consequ	ience of):						
attending for use			d									
deeth d for	Dog H. Other sline!	ficant and 401		. B. A A	1	4.4.			001 014		words and an a	
d by th	Part II. Other signif	ricant conditions	contributing to death	n but not resultin	g in the ur	deflying cause g	iven	in Part I.		Yes 2 No		the cause of death?
requir should										s an autopsy formed?	com	a autopsy findings lable prior to pletion of cause eath?
sician: The lew cartificate has lirector, page 2 a o Be Compi									16	Yas 2□No	16	Yas 2□ No
yslolan: s cartifica director, p	25. Was case refar	rred to medical					2	26. Place of Dea	th (Check only	ona)	1	
2 F 5 W	axaminer?				_	-						

Division o Medical Certification:

To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral

Manner of Death

5 Pending investigation 1 Natural 2 Accident 3 Suicide 4 Driomicide

6 ☐ Could not be detarmined

28a. Date of Injury (Month, Day Year) toum05-10-99 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

P BRUWN LOT

28100PM

1 Yes 2 No

Sussour WAS SHOT

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3305 TOUROTENIN, PRINCE GEORGE t Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and manner as stated.

\*\*Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29a. Certifier (Check only one)

29c. License number O.C.M.E

29d. Data signed (Month, Day, Year) MAY 11, 1999

State

Korzu ow 22. Registrar's Signature

s of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

wed to the

State of Maryland / Department of Health and Mental Hygiene 1 3 5 0 0

		Decedant's Nama (First, Middle	in I and		Certificat		Death	R	eg. No.	11 11	
Physic /Med		samuel N	icholsor					2. Data of Daa Month	9th	Yaar 1999	3. Tima of Death
Exam	iner	4a. Facility Nama (If not institution  Mariner Heal			urel		4b.City,Town,orL Jaurel	ocation of Daath	,		orge's
Funera Directo		5. Social Security Number 577-20-0546		Aga (In yrs. last bi		r 1 Yaar		8. Data of Birth (Month, Day	Year)	9. Birthpla Countr	ace (State or Foreign y)  Carolin
fand m ow		Usual Rasidance of Dacedant 10a. Stata 10b. County		10c. City, Tov	n or Location					10	d. Insida City Limits
death with the Maryland rms 23e or 28a-f show	tor	DC Nor	ne	Was	shingto	n					1 X Yas 2 □ No
er the	Dire	10e. Street and Number			10f. Zip	Coda		1	0g. Citizan of \	What Countr	y?
ath w	rai	134 - 35th St	-			200			US		
after or its	by Funeral Director	11. Marital Status 1 □ Navar Married 2 □ Marri 3 ☒ Widowed 4 □ Divorcad	ied 1 Yas 2	No No	13. Was Daced If Yas, spec		dispanic Origin? (Sp an, Maxican, Puarto Specify:	Rican, atc.)		e - America ck, White, at Bla	tc.
21215-002 d within 72 hours giene. or than "natural",	Completed	15. Decadan (Spacify only higha: Elamantary/Secondary (0-12)	t's Education st grada complated)  College (1-4			rk dona sa ratire	during most of work d)	king	16b. Kind of B		
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larylar 2 should be and Menta s merked	F	19a. Informant's Name/Ralations		198	o. Mailing Addrass	(Straat	and Number or Rui			State, Zip C	Coda)
e, Ma 1 and 2 s Health ar em 27 is ther trau		Samuel Nichol	son, III	Son	1419 9t	h S	t., Gler	narden,	Md.	20706	
0 0 0		20a. Mathod of Disposition  1 ☐ Burial 2 ☐ Cramation	3 □Ramoval from St	20b. Place of	of Disposition (Nar ary, crematory or o	ma of			20c. Location -		
Baltimore, permit. Pages 1 as Department of Hee Important: if Item any Injury or othe		4 ☐ Donation 5 ☐ Othar (S	pecify)		mony Me			5-13-99	Land	dover	, Md.
Bal Bermi Departiment		21. Signature — Funaral Sarvica	11		Ralph	Wi	lliams H	Funeral	Serv:	ice	
		23a Part 1 Enter the disease or	Mille as				St., SI				Approximata
Physician /Medical Examiner	Į.	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a.	V	Consequence of):	20	nia	1		1	Interval Batween Onsat and Death  2 Welks
ecords, P.O. Box 68760, law requires that the death certificate be executed as been signed by the attending physician end 2 should be detached for use as the burial-transit	dical Examiner	Sequantially list conditions, if any, leading to immediata cause. Enter Undarlying Cause (Disasas or Injury that initiated avants resulting in death) Last	b. Kis		consequence of):	Ku	llar,	Accid	and		2 weeks
Box 6 auth certific attending profor use as	Physician/Medical		d							1	
P.O.	Physic	Part II. Other significant condition	ns contributing to deel	th but not resulting I	n tha undarlying c	ause giv	an in Part I.	101 101			the cause of death?
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Rec e law hes t	шb									of de	eath?
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of Vita Physician: this certific ral director,	To Be	axaminar?	Hospital:	patiant 2 ER/O	utpatient 3□ DC	Oth	26. Placa of Daat	h <i>(Check only</i> on oma 5 ☐ Rasida		ar (Spacifu)	
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Hosp 24 hou Funer	edicai	29a. Cartifiar 1 ☐ Certifyin (Check only one)	Physician: To the be Examiner: On the basi and manna	s of examination an	a, daath occurred ad/or Investigation,	at the tin , in my o	na, data and place, pinion, death occur	and dua to tha cred at tha tima, d	ause(s) and ma ata and place,	inner as stated	led. ha cause(s)
To the Hospital within 24 hours To the Funeral completely filled	Me	29b. Signature and title of certifier		M. g	290	. Licans	a numbar 24721	2	9d. Data signed	d (Month, Di	ay, Year)
(2)		30. Nama and address of person of SYEA SASIU	14333 .	Laurel	(Type, Print) BOWI-E	Ry	1. 572	08 d	aurel	ms	20708
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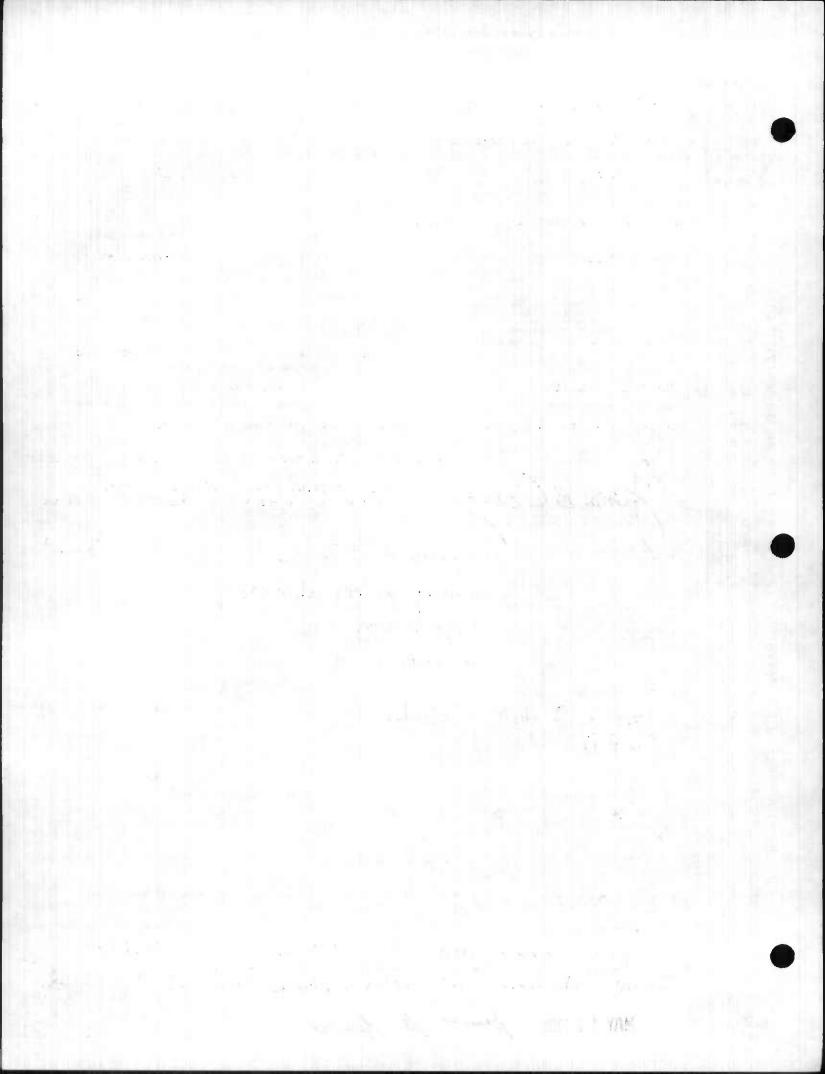
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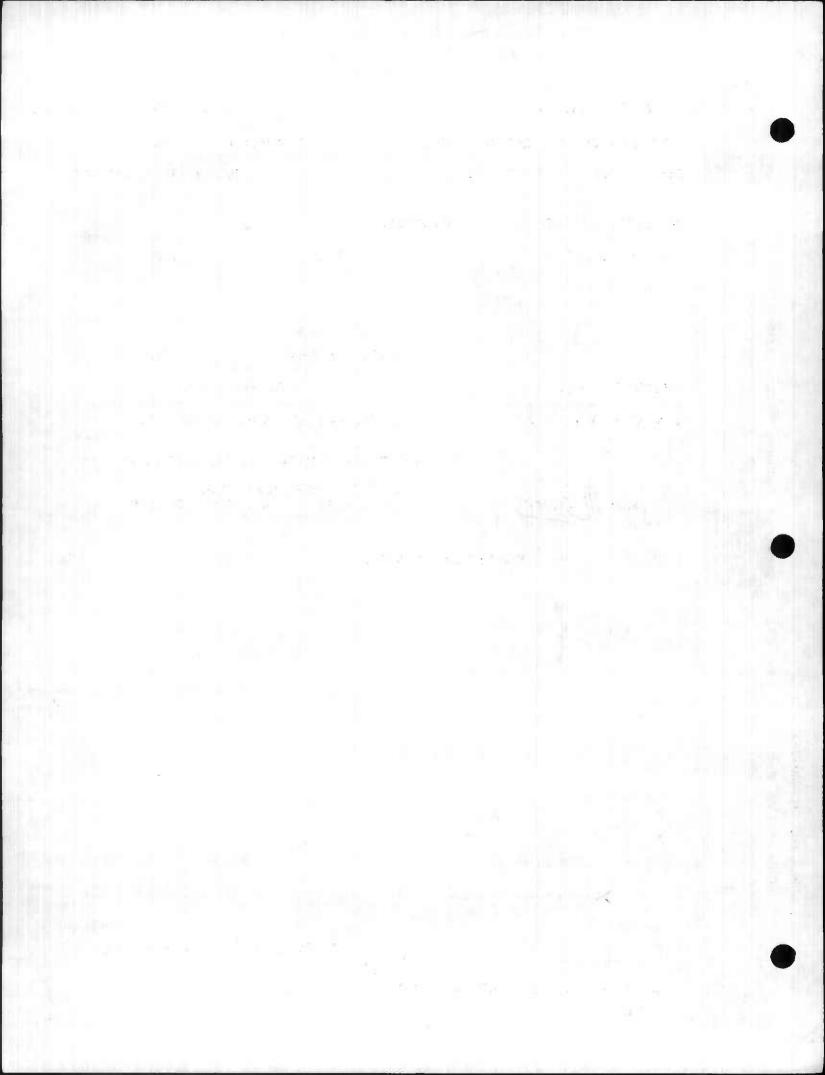
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State of Maryland / Department of Health and Mental Hygiene

	Decedant's Na	ma (First, Middla,	Last)			- 51		2. Dete of De		Yaar	3. Time of Death
Physician (Modical	HELEN	VIRGIN	IIA N	WAILL				MAY	Day 15. 1		1:50 A.M
/Medical Examiner	4a Facility Neme	(If not institution,	give street and nu	mber)			4b. City, Town, or				
	Frederi	.ck Memo	rial Hos	pital			Frederic	k	Fred	derick	
uneral	5. Social Sacurity	Number 6	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Yaa Months Days		8. Data of Bir (Month, Da	rth av. Yaar)	9. Birthpia	ace (Stata or Form
irector	215-16-		1□ M 2⊠ F	7	6 Yrs.	Monano Bay		April	6, 1923		land
	Usual Rasidanca 10a. State	of Decedent		10c Ci	ty, Town or Lo	cation				10	d. Insida City Lin
aho To	100					Cation				10	1 ☐ Yas 2 🛣
or 28a-fa be notified Director	Maryland		lerick	Mt	. Airy	101 71- 0-4-			40- Ohi 41	404 C	
Dir.	10e. Street and N					10f. Zip Coda		- 13	10g. Citizan of		
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The Diam	11. Marital Status	ı ırriad 2□ Marrie	Armed Fo		1,5.	Yas, specify Cu	Hispenic Origin? (S ban, Maxican, Puar	o Rican, atc.)	Bla	ck, Whita, e	
"natural", or	3 Widowed	4 Divorced	If Yas, Gi	iva	1	Yes 20 No	Specify:		Specif	y: Whi	lte
	X	15. Decedant's			16a, Deced	lant'a Usual Occi	pation		16b. Kind of B	usinass/Indu	uatry
plet	(Sp	ecify only highast	grada complatad)		(Give lifa. L	kind of work don OO NOT usa retir	a during most of wo	rking			
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hysician	1. Decedent's Name (First, Middle, La	est)				2. Dete of D		V	3. Time of Death
Medical	SANDRA JANE N	OEL				MAY 1	Day 5 1999	Year	1:00 PM
ner	4a Facility Neme (If not institution, gir	ve street end number)			4b. City, Tov	vn, or Location of Dea	ath 4c. County	of Deeth	
	MEMORIAL HOSPITA			thday) If Under		BERLAND	ALLE	-	
		Sex 1□ M 2\ F 55	(In yrs. lest bir	Yrs. Months	Days Hours	Min. (Month, L	2 1943	9. Birthp Cour MARY	olaca (Stete or Foreign ntry) LAND
	10a. State 10b. County		10c. City, Tow	n or Location				1	0d. Inside City Limit
Director	MARYLAND ALLEGAN	Y	FROST	BURG					1X Yes 2 □ N
5	10e. Street and Number			10f. Zip	Code		10g. Citizen of	What Cour	ntry?
runeral	209 WELSH HIL	·			21532	. 0 (0	U.S.	a Amada	an Indian
	11. Marital Status  1 Never Married 2 Married	12. Was Decedent E Armed Forces? 1 Yes 2 N				gin? (SpecIfy Yes or I , Puerto Rican, etc.)	Bia	ce - Americ ck, White,	
	3 ☐ Widowed 4 🔀 Divorced	If Yes, Give Yeer or Dates:		1□ Yes 2	No Specify:		Specif	WHI	TE
	15. Decedent's E (Specify only highest gr	ducation ade com <i>pleted)</i>	16a.	Decedent's Usua (Give kind of work	l Occupation k done during most e retirad)	of working	16b. Kind of B	usiness/in	dustry
	Elementary/Secondary (0-12)	College (1-4or 5-					HOSPI	ТΔТ	
	17. Fether's Neme (First, Middle, Last	1)		REGISTER		r's Neme (First, Midd			
	RUSSELL E. EVANS				ELI	ZABETH LEV	WIS		
	19a. Informent's Name/Reletionship					or or Rural Route Num		, State, Zip	Code)
	MICHAEL L. NOEL /	SON				HANCOCK, 1	-		
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	camete	f Disposition (Nem ry, cremetory or of	her pleca)	Dete	20c. Location		
	4 ☐ Donation 5 ☐ Other (Speci	fy)	THE CU			Y 5/17/99	CUMBERL	AND,	MD
	21. Signeture of Funeral Service Lice	ns <i>ee</i>			Address of Facility FUNERAL	HOME, P.A.			
_	23a. Pert . Enter the disease or con	MIS that caused	the deeth Do	60 W. N	IAIN ST.,	FROSTBURG,	MD 2153	2	Approximete
	shock, or heart failure. List only	one cause on each lin	е.	not office the mode	or dying, oddina	out of the protect y	011001,		Interval Between Onset and Deeth
	Immediate Ceuse (Final disease or condition	HED LET C	EMCEDIA	A T OD A MINIS					1 HEEK
	resulting In death)	a HEPATIC		consequence of):				1	1 WEEK
Cyalling		h							
7	Sequentially list conditions,	J. I	Due to (or as a	consequence of):					
	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that bridged graphs.)	C						1	
	thet initieted events resulting in death) Last		Due to (or as a	consequenca of):					
1		d							
SIMAIN		d.							
	Part II. Other significant conditions	contributing to death bu	t not resulting l	n the underlying ce	euse given in Part I.	23b. DI	d tobacco use co	ontribute t	o the ceues of deat
		contributing to death bu	t not resulting l	n the underlying ce	euse given in Part I.		d tobacco use co		V
		contributing to death bu	t not resulting l	n the underlying or	euse given In Part I.	1[	Yee 2□ No	3 □ Pro	bably 4 Unkno
out and a second		contributing to death bu	t not resulting l	n the underlying $lpha$	euse given in Part I.	1[ 24e. W		3 ☐ Pro	debuty 4 Unknown of the completion of cause
		contributing to death bu	t not resulting l	n the underlying or	ause given in Part I.	1[ 24e. W	Yee 2 No as en eutopsy dormed?	3 ☐ Pro	dere eutopsy findings reliable prior to impletion of cause death?
and in the second secon	Part II. Other significant conditions of	contributing to death bu	t not resulting l	n the underlying or		24e. Wype	as en eutopsy rformed?	3 ☐ Pro	debily 4 Unknown of the completion of cause
o co completed by ringstoldfilmed	Part II. Other significant conditions of the con				26. Place	24e. Wipe	as en eutopsy dormed?	3 Pro	dere eutopsy findings reliable prior to mpletion of cause death?  Yes 2 No
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000	Part II. Other significant conditions of the con	Hospital: 1 Inpaties 28e. Date of Injur (Month, Day 28e. Placa of Injur building, etc	nt 2□ ER/Ou  Yyear) 28b.  ry - At home, fa  (Specify)  If my knowledge examination an	utpetient 3 DO Time of 2: Injury M arm, street, factory	26. Place  A Other: 4 \( \) Nu  Bc. Injury at Work? 1 \( \) Yes 2 \( \)  at the time, date an	24e. Wipe  10  of Death (Check only rsing Home 5  Received Property Propert	as en eutopsy dormed?  Yes 2 No  y one)  sidence 6 Othe how injury occur  (Street and Num  rown, Stete)	3 Pro  24b. Way of of 11  ther (Special red)	dependent of cause death?  Yes 2 No  Note that the cause death?
0 0	Part II. Other significant conditions of the con	Hospital: 1 Inpaties  28e. Date of Injur (Month, Dey  28e. Placa of Injur building, etc.	nt 2□ ER/Ou  Yyear) 28b.  ry - At home, fa  (Specify)  If my knowledge examination an	utpetient 3 DO Time of 21 Injury M arm, street, factory e, death occurred a	26. Place  A Other: 4 Nu  8c. Injury at Work? 1 Yes 2 december of the control of	24e. Wipe  10  of Death (Check only rsing Home 5  Received Property Propert	as en eutopsy dormed?  Yes 2 No y one) seldence 6 Othe how injury occurred.  (Street and Numfown, Stete)  The ceuse(s) and me, date end plece	3 Pro 24b. W an of of 11 her (Specimed)	deep eutopsy findings reliable prior to mpletion of cause death?  Yes 2 No  No  No  No  No  No  No  No  No  No
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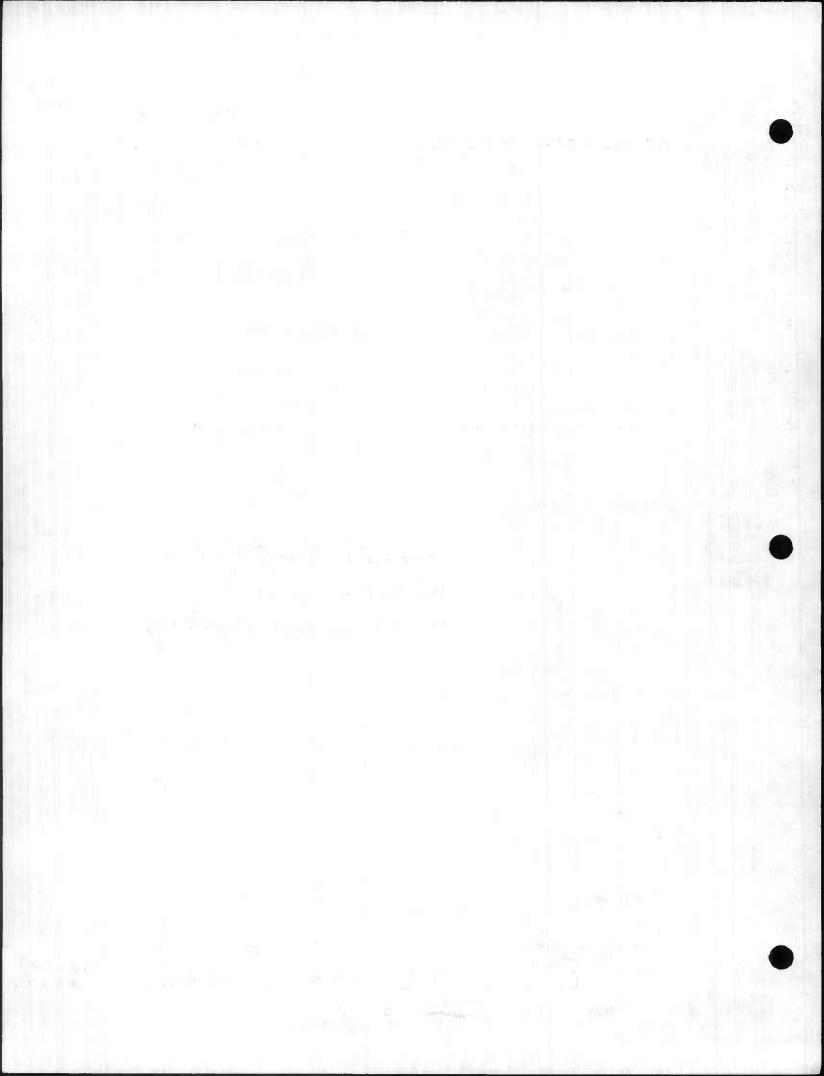
			State o	f Marylan		artment of rtificate o	Health and f Death	Mental Hy	/giene Reg. No.	9 [	7293
	1. Decedent's Nem	ne (First, Middle	, Last)	-0,1107				2. Dete of D	eeth	Mana	3. Time of Deeth
Physician		ELAINE	r NC	RMAN				Month	Day 1/ )99	Year	0950
/Medical Examiner			, give street end nu				4b. City, Town, or			ity of Deeth	
Examine	PENINSU	LA REGI	ONAL MED	ICAL CEN	ITER		SALISI	BURY		WICOM	ICO
Funeral	5. Social Security N		6. Sex	7. Age (In yrs.		If Under 1 Yea	ar If Under 24 Hr	S O Date of B	ieth		plece (Stete or Foreign ntry)
Director	202-01	-9420	1□M 20 F	78	Yrs.	Months Dey	s Hours Mir	(Month, D	/21		ryland
D	Usuel Residence o									1	-1
how	10e. State	10b. County		10c. City	y, Town or Lo	cation					10d. fnside City Limits
the Meryland 28a-1 show notified at	Md	Wico	mico	Не	bron						T Yes 2 No
iter death with the Mei r items 23s or 28s-f s other must be noticled funeral Director	10e. Street and Nu	mber				10f. Zip Code			10g. Citizen o	f Whet Cou	ntry?
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eme 23	11. Meritel Status		12. Was Dec Armed Fo	edent Ever in U,	S.   13. 1	Was Decedent o	Hispenic Origin? ( Joen, Mexican, Pue	Specify Yes or N		ece - Ameri leck, White,	
0 0 5	1 Never Merr			2 No		1 □ Yes 21√2 N			Spec		
iral', o	3 Widowed	4 Divorced	Yeer or D								hite
be filed within 72 hours tel tygiene. d other then "natural;, avent, the Medical Exa avent, the Medical Exa Be Completed by	(Spec	<ol> <li>Decedent cify only highes</li> </ol>	's Education t grade completed)		(Give	dent's Usuel Occ kind of work dor	e during most of we	orking	16b. Kind of	Business/In	
within then then then then then then then the	Elementery/Seco	ondery (0-12)	College (	1-4or 5+)		DO NOT use reti				- 1	elderly
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tt. Partmentant		5 Other (S)						J/ 13	DIVALV	C/ 11	<u> </u>
permit. Pages 1 and 2 should be filed with Department of Health end Mentel Hygiene. Important: if item 27 Is marked other than any injury or other traumatic avent, the sonce.  To Be Comp	21. Signeture of Fu	neral Service	-Moo-	417		2. Name end Add		1 Home	D O	Boy	61
40244	Cornel	w W/A	secre				, Funera			DOX	_
	23a. Pert1. Enter to shock, or hea	the disease, or art failure. List	complications that only one cause on e	caused the deet each line.	n. Do not ent	er the mode of d	ying, such es cardi	ac or respiratory	errest,	1	Approximete Intervel Between Onset and Death
Physician (Madical	Immediate Cours	/Final		1			11 4	;	/		Cristi and Stain
/Medical Examiner	Immediate Cause disease or condition resulting in deeth)	on	θ	Co	200	hue	Heart	tail	me.	1	
- to	,			Due to (o	ras a consec	quenca of):		11.			
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requires that the death certific een signed by the ettending p hould be deteched for use as hould by Physician/Mer	Danill Other stank	diame and distan			dala - la aba da	adad daa daasa	ekine le Deet I	ash Du	d tobacco was	a a metalla se a a	to the cause of death?
by the de teched	Pert II. Other signi	ncant conditio	ns contributing to d	eath dut not resi	uiting in the u	ndenying cause	given in Pert I.		Yas 2 No		
es thet igned b be dete								_	J Tas ZLINC	3 - 110	Unknown
uires the signer and be d									s an eutopsy	24b. W	ere autopsy findings
been si should								per	tormed?	C	veilable prior to ompletion of cause death?
The law require sate hes been single pege 2 should Completed									Yes 2 No		
certificate rector, per	OF Managements	and to modical							/		☐Yes 2☐No
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deat deat ctor: y the	2 ☐ Accident 3 ☐ Suicide	6 Could r	not be gen Bloom	of Injury - At he	ome, farm, str	reet, fectory, offic	:0	28f. Location	(Street and Nu	mber or Rur	ral Route Number,
or Attendir seter death. I Director: Al d in by the fu	4  Homicide	Geterrin	build	ing, etc. (Specify	v)			City or To	own, Stete)		
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.  Medical Certification: To Be	29a. Certifier	12 Cartifyin	g Physician: To the	best of my kno	wledge, deet	n occurred et the	time, date end place	ce, and due to the	e ceuse(s) end	menner es	stated.
he Hospit in 24 hour he Funer pletely fill	(Check only one)	2 Medical I	Examiner: On the b	asis of examine ner steted.	tion end/or in	vestigation, In m	y opinion, death occ	curred et the time	, date and plac	a, and due	to the cause(s)
Nethir Me	29b. Signature end	title of cartifier	1			29c Lice	nse number		29d. Date sig	ned (Month	, Dey, Year)
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^	30. Name and add	ress of person	who completed cau	se of deeth (Item	23al(Type	Print)				111	SOUSBURY
7	T.	L. D.	ward	·	1-1	pn	3154, MC./	00 E.	201/011	51	mb zwol
State	31. Dete filed (Mor	nth, Dey, Year)	32. F	Registrar's Signa	ture	,					
Registrar		MAY 13	1999	Denew	1	Son	ch)				- 1/40

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Baltimore, Maryland 21215-0020

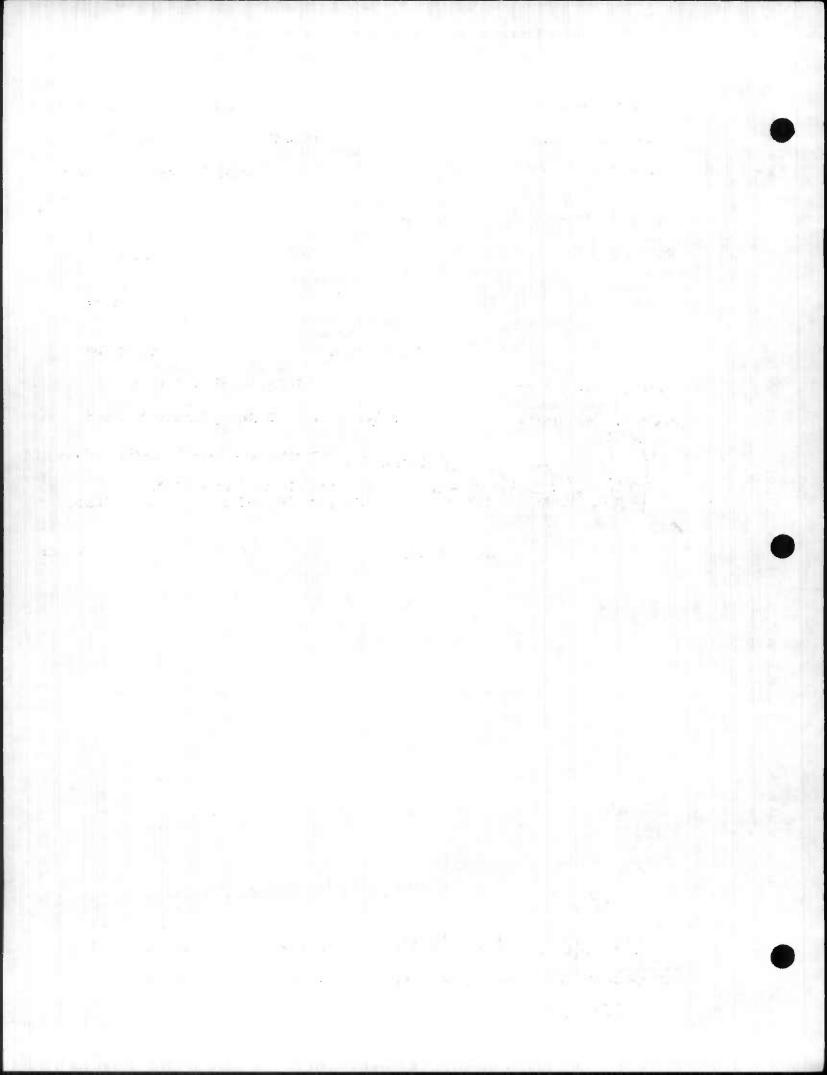
Division of Vital Records, P.O. Box 68760,



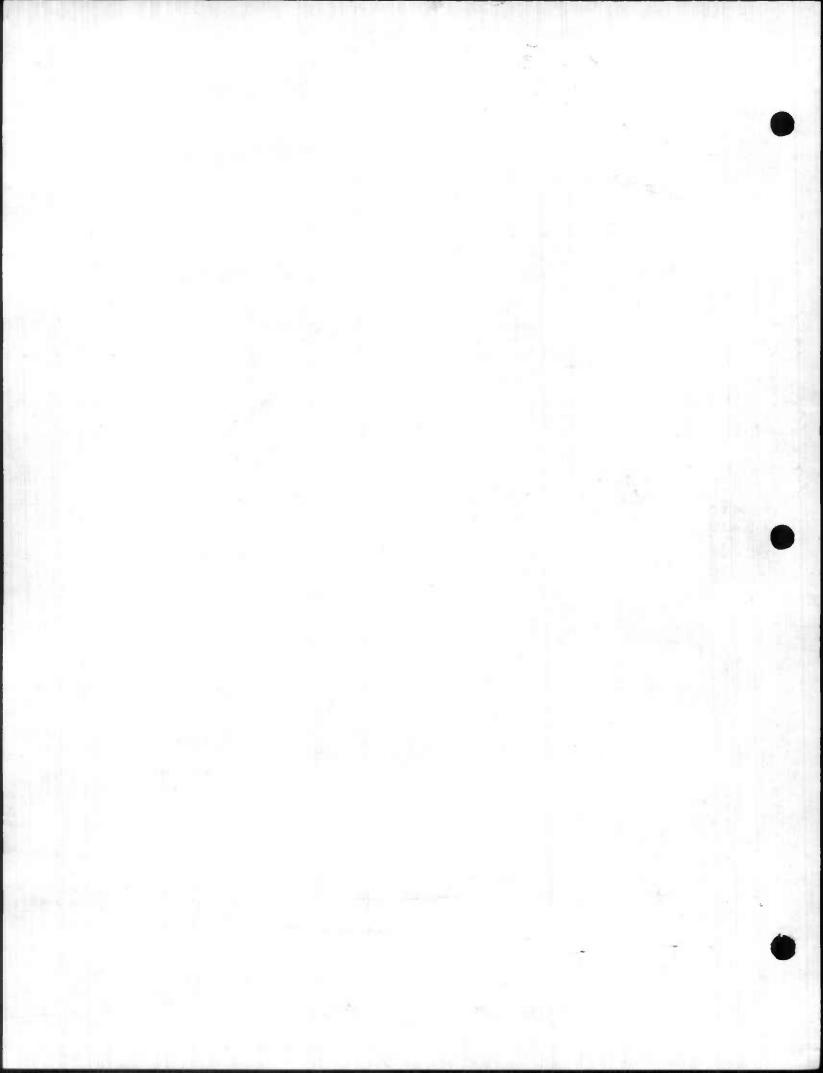
		State of M	faryland		irtment of tificate o		and Mental H	ygiene Reg. No.	1	7294
Discolator	1. Decedent's Name (First, Middle,	Last)		1-10-7			2. Date of I		Year	3. Time of Deeth
Physician /Medical	JOSEPH RALPH	NORRIS					MAY	15°, ]	1999	4:06AM
Examiner	4a Facility Name (If not institution, 9808 SYLVAN '		7)		N	EWBUR	Carrier and the second		y of Death	3
Funeral Director	5. Social Sacurity Number 217-34-1815  Usuel Residence of Decedent	Sex 7. A	ige (In yrs. Ia:	st birthday) Yrs.	If Under 1 Ya Months Day		Min. Jan. 8	Birth Pear) 1938	Cour	place (State or Foreign http:) / land
the Meryland 28a-f show northealst	10a. State 10b. County Maryland Char	les		Town or Lo	cation			No.	1	10d. Inside City Limits 1 ☐ Yes 2 No
fier death with the Me r thems 23a or 28a-1 or free free free free free free free fre	10e. Street and Number 9808 Sylvan Turi	1			10f. Zip Code	20664		10g. Citizen of U.S		itry?
Mr. o	11. Marital Status  1 Never Merried 2 M Marrie 3 Widowed 4 Divorced	12. Was Dacedant Armed Forces d 1 ☐ Yes 2 X If Yes, Giva Yaar or Dates:	? No		Was Decedent of I Yes, specify C		igin? (Specify Yas or n, Puerto Ricen, atc.)	No- 14. Ra Bli Speci	ce - Amaricack, White,	
led within 72 hours lygiene. ner then "netural; nt, tre morral Ex Completed b	15. Decedant's (Specify only highest			16a. Deced	lent's Usual Oci kind of work do DO NOT use ref	cupation ne during mos	st of working	16b. Kind of I	Business/In	dustry
withir she	Elamantary/Secondary (0-12)	Collaga (1-4or	5+)		Driver			Const	ructi	on
= I = a	17. Father's Name (First, Middle, La	ist)					er's Nama (First, Midd	fle, Maiden Sume	ma)	
Mentel Mentel Mentel arrived or aftic ev	James Carroll	Norris				Edi	th Madeli	ne Gatto	n	
ath and A 27 is ma if trauma	19a. Informant's Neme/Relationshi Alice M. Norris,						er or Rural Route Nur Newburg,		n, Steta, Zip 206	
Pages 1 a ent of He ht: If Nem ry or othe	20a. Method of Disposition  1 X British 2 Cremation 3  4 Disposition 5.5 Other (Spe		0.00	matani aran	sition (Neme of netony or other) nited M	n(a aa)	st 05-18-1	20c. Location		, Maryland
Departm Departm Importar Many Inju	21. Signiffure of Furtheral Service Li	Busho	0053	cn Le	The Hu	untt Fu	ineral Home	e, Inc.		
lilew	23a. Part . Enter the diseese, or c shock, or haart failure. List or	omplications that cause	ed the death.	Do not ent			, Waldorf cardiac or respirator		na zi	0604 Approximata interval Between
Physician /Medical Examiner	Immediate Ceuse (Final disassa or condition resulting in death)		CANC	CER as a conseq	uence of):				1	Onset and Death
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ate be hysicia the bur	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c	Dua to (or a	as a conseq	uance of):		-			
etter for u	Part II. Other significent condition	contributing to death	but not result	ting in the u	nderlying cause	given in Part	I. 23b. D	id tobacco use c	ontribute t	o the cause of death?
= 00							1	□ Yee 2□ No	3□ Pro	bably 4 Unknown
s been s 2 should pleted								es en autopsy informed?	6/	Vere autopsy findings vailabla prior to omplation of cause death?
The la							11	☐ Yes ※※ No	1	☐ Yas 2☐ No
ysician: The secreticate director, page Co	25. Was case rafarrad to medical examiner?	Hospital:				Out.	e of Daath (Check on			
7 00	1 Yes 2 YNo 27. Manner of Deeth	28a. Data of Inj		R/Outpatier 28b. Tima of	IL SU DOM	4 L N	ursing Home X6X R	esidence 6 00		fy)
After After fune	1 Actident 5 Pending Invastigation 1 Sulcide 6 Could not	tion to an article	lay Year)	Injury		njury at Work? I 🗆 Yes 2 🗆	INo	n (Streat end Nur		e/ Route Number.
To the Hospital or Atten- within 24 hours after deat To the Funeral Director: completely filled in by the Medical Certifica	4 Homicida datermin	building, e	etc. (Specify)				City or	Town, State)		
the Hospital nin 24 hours the Funeral npletely filled	(Check only 2 Medical Ex	Physician: To the best aminer: On the bests and menner s	of examination		vestigation, In m	ny opinion, dea		ne, data end place	e, end due t	to the cause(s)
with:	29b. Signature and title of certifier  Level	~ M	. M	M		ansa number 28352		29d. Data sign		
	30. Name and address of person w KRISHAN MATHU					LA PL	ATA, MD	20646		

Registrar

State



		, d	State of Marylar		artment of I <i>rtificate of</i>		Mental Hy	giene Reg. No.	17	
		1. Decedant's Nama (First, Middle, Last	1				2. Date of De	eath		. Tima of Death
Physic		Margaret	and the	Ne	son		Month May	Day 12.1999	Year	:50 pm
/Med Exam		4e Facility Neme (If not institution, giva	street and number)	1,0.	5011	4b. City, Town, o	Location of Deat	h 4c. County	of Death	:30 piii
		Mariner Health	Of Southern	n Mary	land	Clinton		Princ	e Geo	raes
Funera	1 0	5. Social Security Number 6. Sec	7. Aga (In yrs.			If Under 24 Hi	s. 8. Date of Bi	rth	9. Birthplace Country)	(Stata or Foraign
Directo		579-28-1675	M 200 F 92	Yrs.	monins Days	110013	Febuar	y 14,0	7 Mar	yland
p .		Usual Residence of Decedant  10c. Stata 10b. County	10c Ci	ty, Town or Lo	cation				104	Inside City Limits
aho	5			ty, rount or Ec	- 4.14					Yas 2 No
the N	Director	Maryland Prince 10e. Street and Number	Georges		Aquasco 10f. Zip Code	0		10g. Citizen of \		
A P	5					0.000				
eath m 23	era	22907 Aquasco R	CI 12. Wes Decedent Evar in U	IS. 13.1		0608 Hispanic Origin?	Specify Yas or No	U . S	e - Amarican I	ndien.
Q Z1Z15-UUZU (iled within 72 hours efter death with the Maryland Hygiene. (the than "natural", or flarma 23a or 28a-f show out, tre Heddest Extra continued.	Funeral	1 Navar Married 2 Married	Armed Forcas?		Wes Decedent of I f Yas, specify Cub	an, Mexican, Pue	rto Rican, atc.)	Blad	ck, Whita, atc.	
aryland 21215-UU2U should be filed within 72 hours of end Mentel Hygiene. emarked other than "natural", or umatic event, tre Heddell Entre	by	3 □XWidowed 4 □ Divorced	If Yas, Giva Yeer or Detes:		1 ☐ Yes 2 ☒ No	Specify:		Specify	Black	
72 hours	Be Completed	15. Decedent's Edu		16a. Dece	dent's Usual Occu	pation	nation a	16b. Kind of B		ry
Z und	pje	(Specify only highest grad	Collega (1-4or 5+)	lifa.	kind of work done DO NOT use retire	iduring most or w id)	orking	3500		
N N N N N N N N N N N N N N N N N N N	NO.	12		Нс	memake	c		Dom	estic	
aryland 2121 should be filed within and Mentel Hygiene. marked other than numetic event, tre H	Be	17. Fathar's Nama (First, Middla, Last)				18. Mother's N	ame (First, Middle	, Maiden Suman	na)	
arylan should be nd Mentel marked o	0	Arthur	But	ler		Ada			Sa	voy
E (4 - 2 -	4	19a. Informant's Name/Ralationship (Ty		19b. Meili	ng Address (Stree	t and Number or i	Rural Route Numb	er, City or Town,	Stata, Zip Co.	da)
C - 01 .		Margaret Neal/D		22907	Aquas	co RD, A				
Pages 1 nent of H int: if her		20a. Mathod of Disposition 1 □ Burial 2 □ Cramation 3 □ F	emover from State		sition (Nama of natory or other pla		Data	20c. Location		Stata
altimore, mit. Pages 1 ar partment of Haa portant: if Item 2 y Injury or other		4 Donetion 5 □Other (Specify)	Res	surrec	tion	May	17,99	Clint	on M	D
baltimo permit. Page Department of Important: If i eny Injury or		21. Signature of Funaral Sarvice Licans	DO A	22	. Nama and Addr	ess of Facility				
4 405 6		Lloux M.	Estas )		AMS FUI				SCO M	D 20608
Physician /Medica Examiner	1	23a. Pert1. Enter the diseasa, or complished, or heart faffure. List only or immediate Causa (Final diseasa or condition resulting in deeth)	chra		renal		aftici		On	set and Death
death certificate be asscuted e attending physician end ed for use as the burial-transit	Physician/Medical Exar	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting In death) Last	,	or as a conseq						
death death of or or or or or or or or or or or or or	sicie	Part II. Other significant conditions cor	stributing to death but not res	ulting In tha u	nderlying cause gi	iven in Pert I.	23b. Did	tobacco use co	ntributa to the	e cause of death
ras that the designed by the a	by Phy	Per	ipherry v	asa	res d'	3.	10	Yes 2 No	3 Probab	ly 4 Unknow
requi been should	Completed b	A	nemie					s an autopsy ormed?	availal	autopsy findings ble prior to etion of cause th?
2 2 2	E O						10	Yes 2 No	1 🗆 Y	as 2 No
en:	Be	25. Was casa rafarred to medical exeminer?				26. Place of D	eath (Check only	one)		
Of VICAL Physicien: Tribis certificat rail director, p	To	1 ☐ Yes 2 1 No	lospital: 1 Inpatient 2	ER/Outpatier	t 3 DOA	her: 4 Nursing	Home 5 ☐ Res	idence 6 DOtt	ner (Specify)	
UIVISION OF bl or Attending Phy s after death. I Director: After this od in by the funeral of	Certification:	27. Mannar of Death  1 DaNetural 5 Panding 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo	rry at ork? ] Yes 2 □ No	28d. Describe	how injury occur	rred	
S after d	Certifi	3 Suicide 6 Could not be 4 Homicide datamined	28a. Place of Injury - At h building, atc. (Specif	oma, farm, sti	eet, factory, office			(Street and Numi wn, State)	ber or Hural R	outa Number,
To the Hospital or A within 24 hours after To the Funeral Direc completaly filled in b	edical (	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	nician: To the best of my knowner: On the basis of examine and mannar stated.	wiedge, deat ation and/or in	occurred at the t vestigation, in my	ime, date and pla opinion, death oc	ce, and due to the curred at the time	cause(s) and m , date end place,	enner as state and due to the	d. e cause(s)
withir To th	Z	29b. Signetura end title of certifiar			29c. Licen	se number		29d. Date signe	d (Month, Day	r, Year)
		2	me -		DU	6478		5-13.9	19	
		30. Nama and addrass of person who co		n 23a) (Type,	Print)	7 0	01404			-
S	tate	31. Data filed (Month, Day, Year)	32. Registrar's Signa	atura	rattsR		CUMIT	מחיותט	XUTS	>7
Regis		MAY 17 19	199	5	. Apon	KS				



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State of Maryland / Department of Health and Mental Hygiene

nnny	Lee Oate	es			, , , , , , , , , , , , , , , , , , , ,	Certif	icate d	of Death		Reg. No.	te hi	
1	Physician /Medical	1. Decedent's Na JOHNN	me (First, Middle, La Y LEE O						2. Dete of D Month May	Day	Year	3. Time of Death 8:47 A.M
	Examiner	4a Facility Name	(If not institution, giv	e street and numbe	r)			4b. City, Town, or	Location of Dea	th 4c. Count	y of Death	
			al Hospita			1 44		Cumber:			legany	3-13 113
	Funeral Director	5. Social Security	-8113	Sex 7. A	36		Under 1 Ye onths Day			hirth (Near) (1962)	9. Birthple Countr MARY	ace (Stete or Foreign ry) LAND
4.5	2	Usuei Residence	of Decedent  10b. County		10c. City. To	wn or Location	on .				10	d. Inside City Limits
	with the Marylar a or 28a-f show the notified at Director	WV	MINER	ΔТ.		r Ash						1 ☐ Yes 2√ No
	or 28e-fr be notified Directo	10e. Street and N		. 1	1 OK.		Of. Zip Cod	0		10g. Citizen of	What Countr	ry?
	Sa or st be	ROUTE	2, BOX	210			267	719		U.S.	. A .	
020	natural, or items 23 lical Examinar must sted by Funeral	21	orried 2 Merried	12. Wes Deceden Armed Forces 1  Yes 2 Y If Yes, Give 2	? ] No		Decedent of s, specify C	of Hispanic Origin? ( Suban, Mexican, Pue No Specify:	Specify Yes or N rto Rican, etc.)	Io- 14. Ra Ble Speci	ca - America eck, White, e	tc.
21215-0020	natura Scal E	(Sn	15. Decedent's Ed	ducation	16	Sa. Decedent	s Usual Oc	cupation ne during most of wo	odkina	16b. Kind of E	Business/Indu	ustry
121	ed within 72 ho ygiene. er then "naturn r. the Medical. Completed	Elementery/Ser	condery (0-12)	College (1-4o	5+)	life. DO I	VOT use rei	tired)				
		17 Fether's Nem	e (First, Middle, Last)			LABO	RER	19 Mother's No	me /First Middl	MAII le, Maiden Sume	VTENA:	NCE
Maryland	a sees		C. OATES							SPENCE		
2	2 should and Mer is marks sumatic		Neme/Relationship (	Type, Print)	19	9b. Meiling A	ddress (Str	eet end Number or F			_	Code)
_	and 2 is bailth ar ar 17 is		JANE OAT.					90 - FOR			26719	
e,	1 Hos Hem: othe	20e. Method of Di	isposition		20b. Plece	of Dispositio	n (Name of		Date	20c Location		m, Stete
Baltimore,	Page ment o ant: If lury or		2 ☐ Cremetion 3 ☐ 5 ☐ Other (Specif		POTOM	C MEM	ORIAL	GARDENS	5/15/99	KEYS	ER, WV	7
Ball	Depart Import any in	Agn	Funeral Service Licer	pokeus	N	P.O	HURCH BOX	dress of Fecility FUNERAL 1 1260-FORT	ASHBY, V	W 2671	9	
•	Physician /Medical Examiner	Immediate Cause disease or condit resulting in death	in disease, or constant filter. List only a (Finel tion	olicetions thet cause one cause on each	ed the deeth. Diline.	o not enter the	e mode of	1		arrost,	i	Approximete Intervel Between Onset and Deeth
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. Box	death cer e attendir d lor use	Part II. Other alon	ificant conditions o	ontributing to death	but not resulting	in the under	lvina causa	Oiven in Part I	23h Di	d tobacco use c	ontribute to	the cause of death
, P.O	requires that the death cert seen signed by the attendin should be detached for use eted by Physician/W						,,,,,,			Yes 2□No	. 1	
of Vital Records,	\$ 50 D								24a. We per	es an eutopsy formed?	ava	re autopsy findings ilable prior to apletion of cause eath?
E B	The la ate he page								1	Yes 2□No	172	Yes 2□ No
/ita	yalclan: The scentificate director, page	25. Was case refe exeminer?	erred to medical	Al control of					eth (Check only	one)		
of	T did	1 Yes 2		Hospitel: 1 Inpat	43		DOA		1	sidence 6 🗆 Ot		)
vision	on the Co	27. Menner of De 1 Neturel 2 Accident	5 Pending investigation		ey Year) 28b	. Time of Injury		njury et Nork? I 🗌 Yes 2 🗌 No	28d. Describe	e how injury occu	rred	
N S	Attendi ector: A by the f	3 ☐ Suicide	6 Could not be determined	28e. Place of la	njury - At home,	ferm, street,	factory, offi	C9	28f. Location	(Street and Num	ber or Rural	Route Number,

29e. Certifier

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) end manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

O.C.M.E.

May 13, 1999

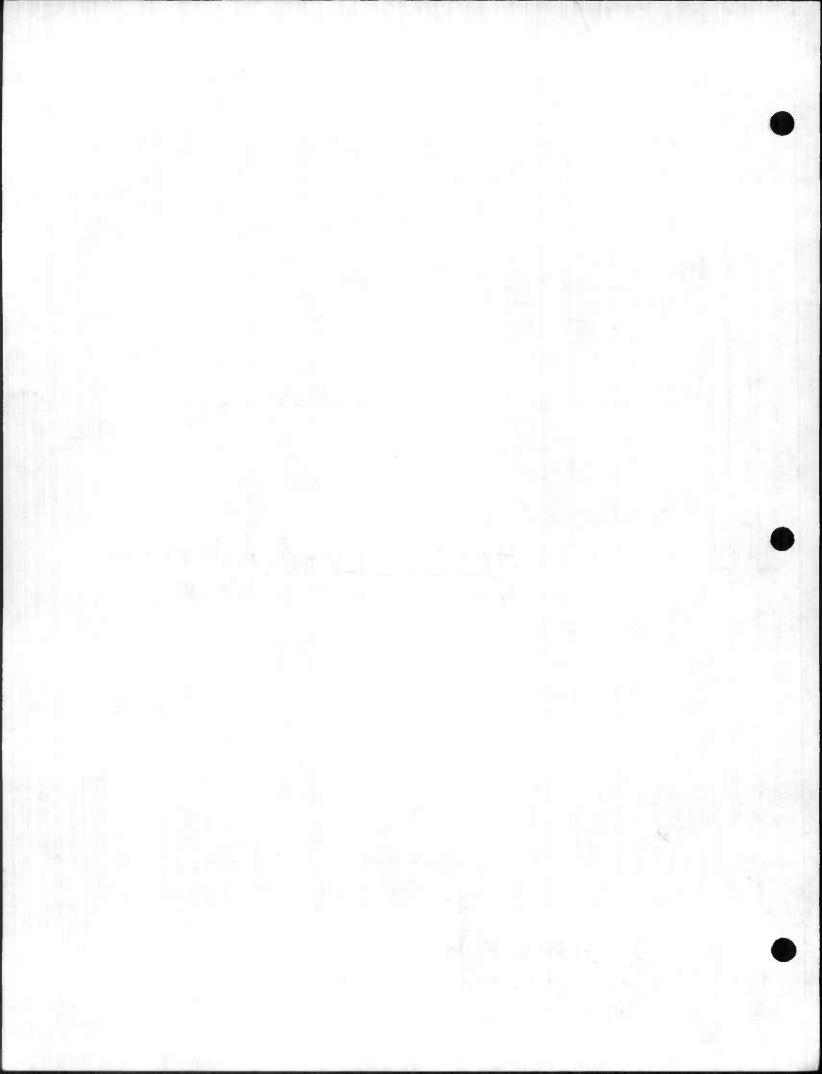
of person who completed cause of death (Item 23a) (Type, Print) mer 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month) Dey, Year) State

Registrar

5

Medical Cer



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Month **Physician** Thomas Willard Oakes 1999 3:15AM May 12, /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner 505 Congress Avenue Havre de State of Birth (Month, Dey, Year)

Hours Min. Dec. 17, 1926 Maryland Havre de Grace Harford if Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Deys 1**X** M 2□ F Yrs. 214-22-3977 72 **Director** Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1√2 Yes 2 □ No Directo Maryland Harford Havre de Grace 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code with 7 is marked other than "natural", or items 23s or traumstic event, the Medical Examiner must be 21078 USA 505 Congress Avenue, Apt. 703 Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bieck, White, etc. filed within 72 hours after 1 TYas 2 No If Yee, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 TNo Specify: White by 3 Widowed 4 ☐ Divorcad Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coliaga (1-4or 5+) Refinery Accountant 12 18. Mothar's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mantal h Anna (UNK) Swamley Bernard R. Oakes 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1803 Belvedere Road, Port Deposit, MD 21904 Anna T. Hickman/Daughter Haalth Item 27 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6 5/17/99 Fallston, MD Highview Mem. Gardens 22. Name and Address of Facility
Howard K. McComas III Funeral Home, P.A. 21. Signature of Funeral Service Licensee Part! Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, ehock, or heart failure. List only one caused each line. 1317 Cokesbury Road, Abingdon, MD 21009 Approximete Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 19 years a Coronary Artery Disease **Examiner** Dua to (or as a consequence of): Examiner physician and the burial-transit the death certificate be executed Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequenca of): 88 for use signed by the a 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No by 24b. Were autopsy findings evailable prior to completion of cause of dasth? 24a. Was an autopsy performed? Completed certificate has b 1 ☐ Yes 2 ☐ No 25. Was case raferred to medical examinar? Be 26. Place of Death (Check only one) To Hospitai: Other: 4 ☐ Nursing Home 5 ☐ Rasidanca 6 ☐ Other (Specify) 1 | Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28d. Dascribe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: Attar 5 Pending Investigation 1 X Natural 1 Yas 2 No death. 2 Accident after death Director: 6 Could not be datermined To the Hospital or Atterwithin 24 hours after des To the Funeral Directo completaly filled in by the 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

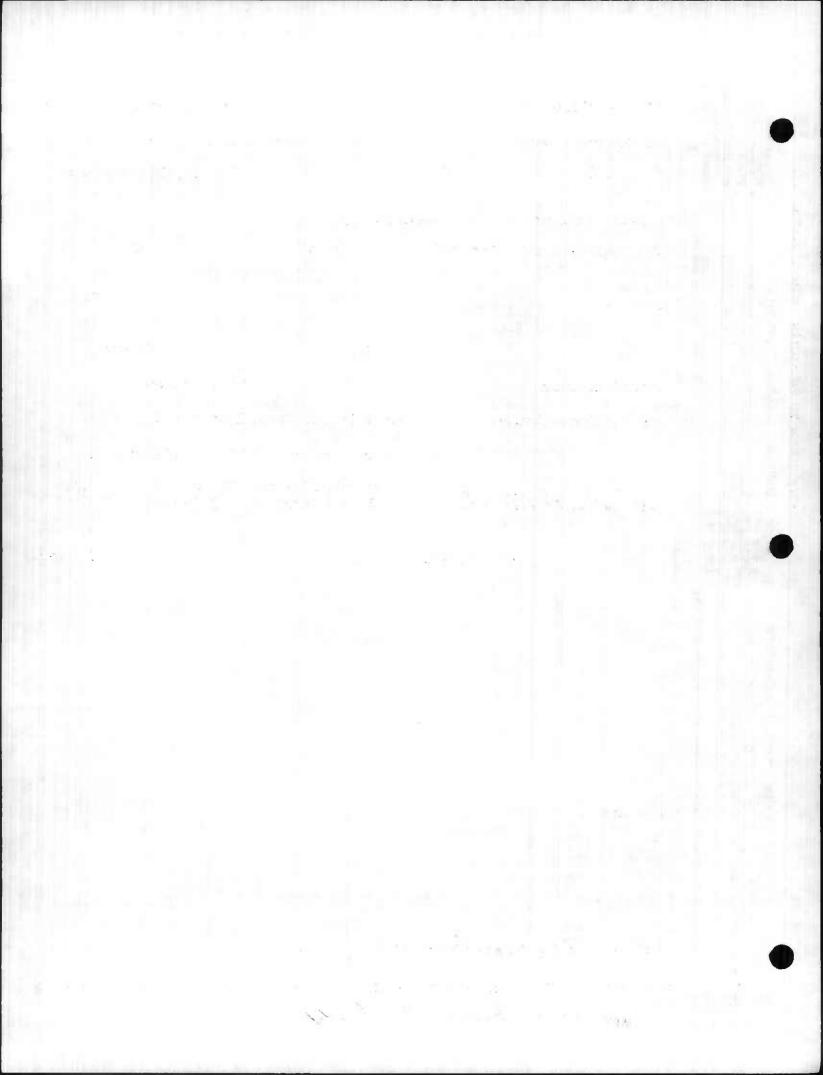
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifian Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Wellan Russ. D21779 May 12, 1999 30. Name and addrass of parson who completed causa of daath (Itam 23a) (Type, Print) VIJAY NELLORE, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MARYLAND 21902 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

DHMH 16 Rev 6/95

Registrar

MAY 1 4 1999



2. Data of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) Month 05 Day 13 **Physician** GONZA EDWARD PINKNEY 99 0300 /Medical 4b. City, Town, or Location of Daath 4c. County of Death 4a Facility Nema (If not institution, giva street and number) Examiner PRINCE GEORGE'S HOSPITAL CENTER CHEVERLY PRINCE GEORGE'S 8. Data of Birth (Month, Day, March 22, Birthplaca (Stata or Foreign Country) If Under 1 Year Months Days II Undar 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Sacurity Number **Funeral** 12 M 2 F Days Hours Min 79 Yrs. 577-22-5976 Maryland Director Usual Rasidance of Dacedant with the Maryland 10a Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryla Department of Haaith and Mental Hygiena. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any fujury or other traumatic event, the Medical Expriner must be needed. 1X Yas 2 No Maryland Director Prince George's Lanham 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? U.S.A. 3022 Brightseat Road, #102 20706 Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No 14. Raca - Amarican Indien, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: by 3 Widowad 4 Divorced **Black** Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Dacedant's Education (Specify only highast grada complated) Elemantary/Secondary (0-12) Collega (1-4or 5+) Private 6th Construction Worker 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Father's Nama (First, Middla, Last) Be (Unknown) Mary Savoy 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Alice Shepherd/Daughter 7803 Muncy Road, Landover, Maryland 20785 20a. Mathod of Disposition 20b. Place of Disposition (Name of cematary, crematory or othar placa) 05/18 20c. Location - City or Town, State 1 Burial 2 □ Cramation 3 □ Removel from State Harmony Memorial Park Landover, Maryland 1999 4 Donation 5 Other (Specify) 22. Neme and Addrass of Facility 21. Signatura of Funeral Sarvice Licensee J.S. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intarval Batween Onset and Deeth **Physician** /Medical Immediata Ceusa (Final METASTATTE JUNG disaasa or condition rasulting In daath) CANCEA **Examiner** Due to (or as a consequence of): Examiner 000 NUTTITION physician and the burial-transit certificate be executed Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disaasa or Injury that initiated events rasulting In daath) Last Dua to (or as e consequenca of): Box 68760, SEVERE Anemin Physician/Medical Dua to (or as a consaquanca of): 23.50 LIVER metesiasis US6 signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying causa givan in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 ☐ Y88 2 ☐ No 3 □ Probably 4 Unknown ON LIASTATTE Prosi ATE p 24b. Wara autopsy findings available prior to complation of cause of daath? 24a. Was an autopsy Completed 'bernomed' page 2 1 Yas 2 No 1 Yas 2 No certificate Division of Vital 25. Was case referred to medical exeminer? 26. Placa of Death (Check only ona) Be Hospital: Othar: 4 Nursing Homa 5 Rasidence 8 Other (Specify) P 1 Nonpatient 2 ER/Outpatient 3 DOA 1 Yas 2 No funeral 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 27. Mannar of Death 28b. Tima of 28c. Injury at Work? Certification: 1 DNatural 5 Panding 1 Yas 2 No invastigation 2 Accidant after deat Director: 6 Could not be datarmined 3 ☐ Suicida Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 4 Homicida 8 24 hours Funaral 18 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiar Medical (Check only one) To the 7 You the 9 Complet 29d. Data signed (Month. Dav. Year) 29c. Licensa number 29b. Signatura and titla of certifiar 038965 30. Name and address of person who completed causa of daath (Item 23a) (Type, Print) Samuel E. Wilson, M.D., 3001 Hospital Drive, Cheverly, Maryland 20785 31. Data filed (Month, Day, Year) 32. Ragistrar's Signatura

**DHMH 16 Rav 6/95** 

State

Registrar

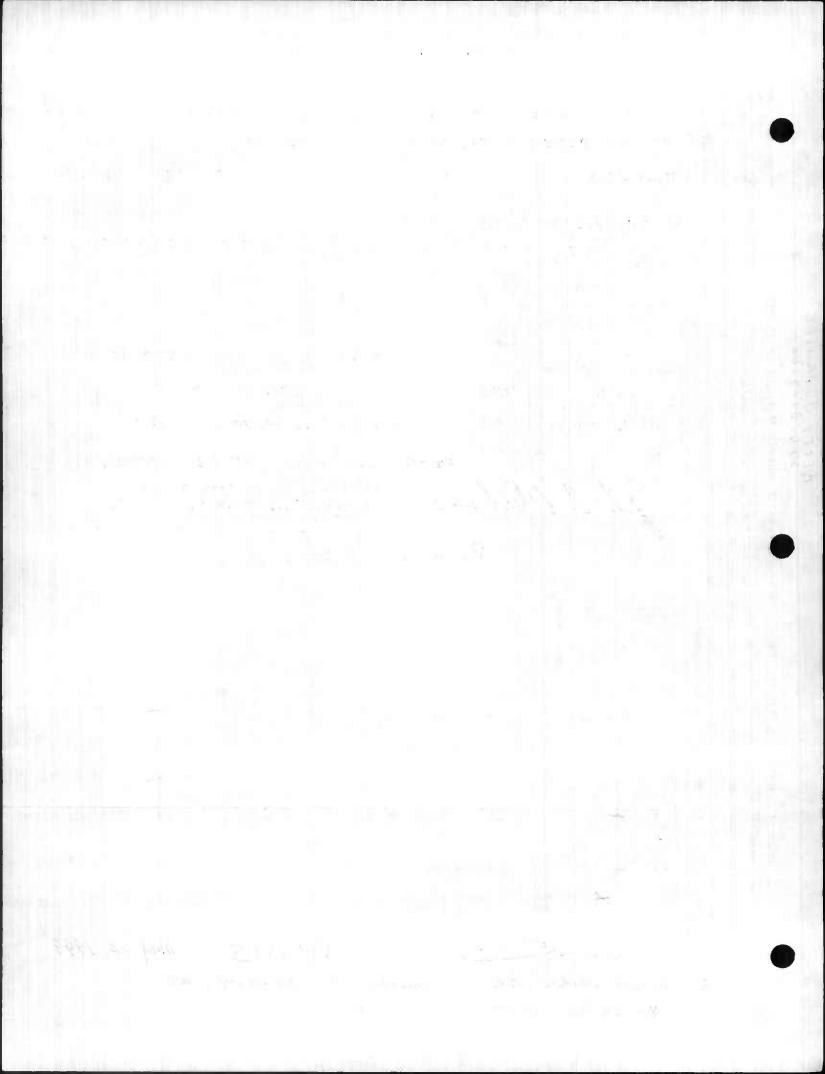
MAY 1 4 1999

State of Maryland / Department of Health and Mental Hygiene

	Decedent's Name (First, Middle, Last)		Certifica	ate of	Death	2. Date of De	Reg. No.		3. Time of Deeth
Physician		Pruitt				Month MAY 1		Year	0550
/Medica Examine	de Caritte Blame III and Institution when at				4b. City, Town, or L	Marie Control	-	Death	0370
	PENINSULA REGIONAL	MEDICAL CEN			SALISBU	RY	WI	COMI	СО
Funeral Director	5. Social Security Number  6. Sex 1 Usual Residence of Decedent	7. Age (In yrs. Ia	Yrs. If Un Monti	der 1 Year hs Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 07 10			ace (State or Foreign ry) ginia
show	10a. State 10b. County	10c. City,	Town or Location					10	d, Inside City Limits
within 72 hours after death with the Meryland ene. than "natural", or items 23a or 28a-f show the Medical Expension must be notified a	Virginia Accomack	County Ta	angier						1 X Yes 2 □ No
ath with the Mer 23s or 28s-f s	10e. Street and Number		10f.	Zip Code			10g. Citizan of Wi	nat Coun	lry?
23e	P.O. Box 167			234			USA		
fler death v	11. Marital Status	2. Wes Decedent Ever in U,S Armed Forces?	S. 13. Wes De If Yes, s	cedent of F specify Cube	lispanic Origin? (Sp en, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Rece Bleck	White,	
urs aft		Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes:	1 □ Yes	2 No	Specify:		Specify:	Whi	te
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tra tra	Gil H. Pruitt	Son			t., Onanc			1016, ZID	C000)
- 9 E E	20a. Method of Disposition	20b. Pie	ece of Disposition (i	Nema of	1	Date	20c. Location - C	ity or To	wn, State
Pages nent of 1 ant: If its arry or of	1 🛱 Buriel 2 ☐ Cremation 3 ☐ Rel 4 ☐ Donation 5 ☐ Othar (Specify)	moval from State	rview Lav			5/14/99	Onanco	ick.	VA
교원관금.	21. Signature of Funeral Service Licensee		22. Name	end Addre	ss of Facility			, ,	***
Depa Impo any i	23a. Paul V. Enter the disease, or complice shock, or heart failure. List only one	lellians	Wil	liams	-Onancocl	Funera	1 Home VA 234	117	
Physician /Medicai Examiner	Immediate Cause (Final disease or condition resulting in death) e.	Pulm.	as a consequence	End 3					Onset and Death
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5 00								-	
death	Part II. Other significant conditions contri	ibuting to death but not rasul	iting in the underlyin	ng cause giv	ven In Part i.	23b. Dld	tobacco use con	ribute to	the cause of death
w requires thet the death cert been signed by the attending should be detached for usa	Colonas	Diren Di	Sence			10	Yes 2⊡nyo	3 🗆 Prot	eably 4 ☐ Unknow
> 10 00 =						24e. Was parto	en eutopsy rmed?	coi	ore eutopsy findings hilable prior to impletion of cause daath?
Physician: The levithis certificate hes al director, page 2						10	res 250 No	1 🗆	Yas 2□No
clan: entific ector,	25. Was case referred to medical examiner?	enitel		011	28. Place of Dea	th (Check only o	one)		
offer deeth.  Director: After this certification by the funaral director.  To Be for the funaral director.	TLI TAS ZIZINO		ER/Outpatient 3 28b. Time of Injury M	DOA Oth	4 LI Nursing H		dence 8 Othe		()
To the Hospital or Attending Phwithin 24 hours effer deeth. To the Funeral Director: After th completely filled in by the funeral Macalical Certification.	3   Suicide 6   Could not be daterminad	28e. Piece of injury - At hor building, etc. (Specify)	me, ferm, street, fac	etory, office		281. Location ( City or To	Street end Numbe vn, State)	r or Rura	l Route Number,
To the Hospital or J within 24 hours efter To the Funeral Dire completely filled in E	29a. Certifier (Check only one) Certifying Physic 2 Medical Examine	cien: To the best of my know ir: On the basis of examination end manner stated.	riedga, daath occurr on end/or Investigat	red at the til	ma, date and placa, opinion, deeth occur	end due to tha red et the time,	ceuse(s) end mar date and place, a	nar es si nd dua to	ated. tha cause(s)
To th To th comp	29b. Signeture and title of cartifier			29c. Licens	se number		29d. Dete signed	(Month,	Dey, Year)
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4	30. Name end eddress of parson who com	m.0.	M11. GO10	51.	SALISE	suld,	mo		
State Registrar	31. Date filed (Month, Dey Year) MAY 1 8 1999	32. Registrar's Signatu	ure Appen	61					

DHMH 16 Rev 6/95

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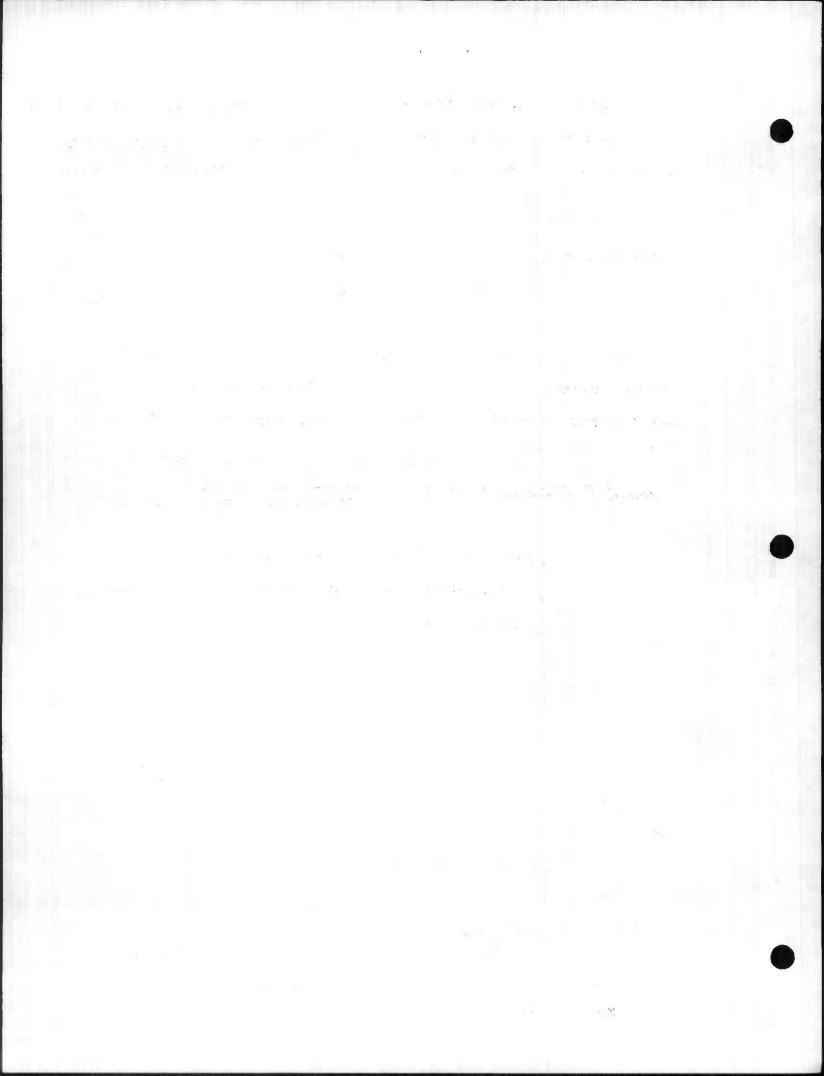
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** PARKER JE ANNE SIGRIST 6:15 Pm 1999 MAY 14 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner OF MARYLAND UNIVERSITY BALTIMORE Baltimore City 8. Date of Birth (Month, Day, Year) 1/29/1962 5 Social Security Number 7. Aga (In yrs. last birthday) If Under 1 Year If Undar 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Min 1 M 2 MF Months Hours 213 80 0950 Yrs. Maryland Director Usual Residence of Decedent 10d. Inside City Limits the Merylend 10c. City, Town or Location 10a State 10b County 7 is marked other than "naturel", or frams 23a or 28a-f show traumatic event, the Modical Examples must be notified at Salisbury Yes 2 No MD Wicomico Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With USA 21801 418 Virginia Avenue Funeral death 12. Was Decedent Ever In U.S. 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amaricen Indian, 11. Marital Status Armed Forces?

1 Yea 2 No
If Yes, Give
Year or Dates: Black, White, etc. Peges 1 end 2 should be filed within 72 hours efter or nent of Heelth and Mentel hygiene. In: If Idem 27 Is marked other than "neturel", or flor Iny or other traumatic event, I'm Medical Exprise. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grada completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Accounting 12 18. Mother's Name (First, Middle, Maiden Sumama) 17. Fathar's Name (First, Middle, Last) Joyce I. Webster Paul Earl Sigrist 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 7790 Hayward Rd., Pocomoke City, MD 21851 Paul E. Sigrist (father) Baltimore, 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 D'Burial 2 □ Cramation 3 □ Removal from State Department of Important: If any Injury or page. 4 ☐ Donetion 5 ☐ Other (Specify) 5/19/99 Pocomoke City, MD Ouinton Cemetery 21. Signatura of Funeral Sarvice Licensee 22. Name and Address of Facility Holloway-Melson Funeral Home m01129 Meihael 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest,

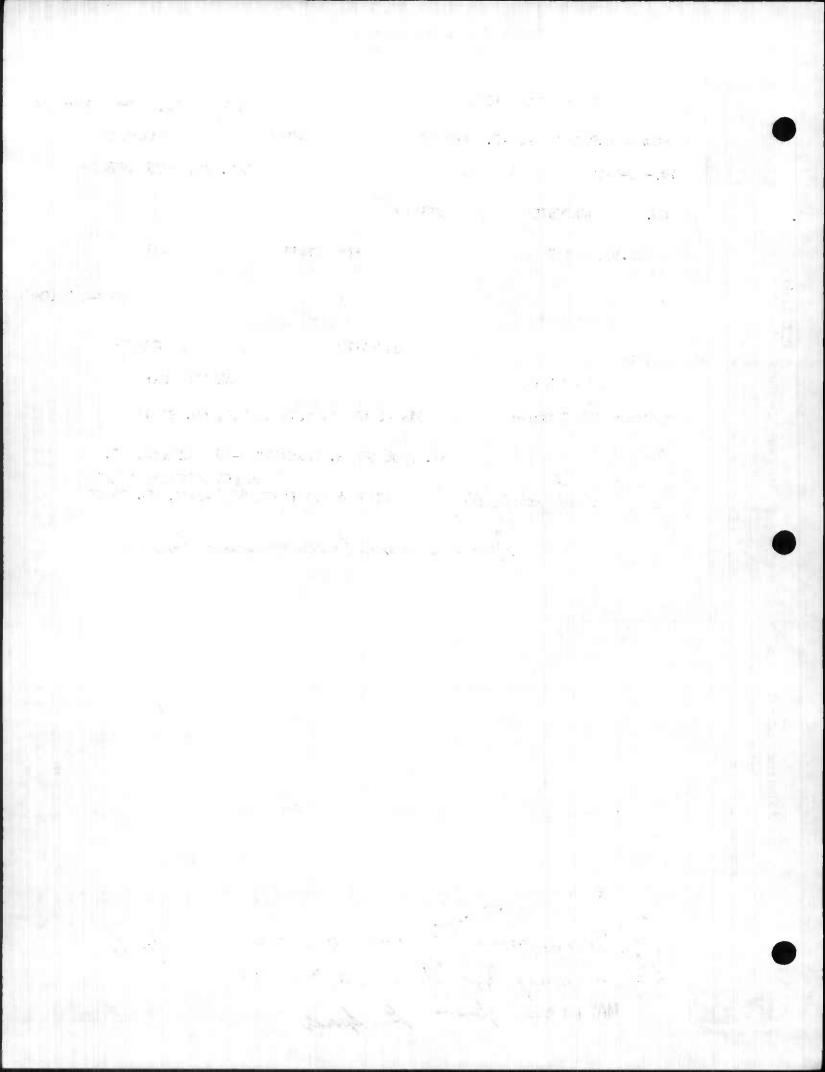
Approximately approximately A Dean Approximete Interval Between Onset and Death **Physiclan** /Medicai Immediate Cause (Finel @NON-HODGENS LYMPHOMA, RELAPSE disease or condition resulting in death) Examiner Examiner ALLOGENEIL Stem cul THANSPLANT From RELATED DOWN physician end s the buriel-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of): that the death certificate be exec HYPCRKALEMIA Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) 60 USA 0 signed by the at d be deteched for 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown by 24b. Were autopsy findings available prior to 24e. Was an autopsy Completed completion of cause of death? page 2 has 1 Yaa 2 No 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: funeral director. 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) Hospitai: 1 Dinpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 L 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury et Work? After 1 Neturel 5 Pending Investigation after deeth. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours a Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hosp within 24 hou To the Funer completely fil 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific P11769 may 14, 1999 30. Name and address of person who completed ceuse of death (item 23e) (Type, Print) BALTIMORE, MD 21201 JOSEPH P. HONDHITAND, MD 22 S. Corcene St 31. Date filed (Month, Day, Year) MAY 18 1999 32. Registrar's Signature State

Registrar **DHMH 16 Rev 6/95** 



Baltimore, Maryland 21215-0020  Permit. Peges 1 end 2 should be filed within 72 hours effer death with the Maryland Department of the files and Mental Hygiene.  Important: If item 27 is marked other than "netural", or items 23a or 28e-f show any injury or other traumetic event, the Medical Examinet.  To Be Completed by Funeral Director	4e Fecility Neme (If not institution, given BERLIN NURSING 5. Social Security Number 6. State 197-12-0129  Usuel Residence of Decedent 10e. Stete 10b. County MD WORCES 10e. Street end Number RTE 50, & 113 11. Menitel Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced (Specify only highest grant Elementary/Secondary (0-12) 7 17. Father's Name (First, Middle, Last LEE PURN 19e. Informant's Name/Reletionship (ROBINSON BRITTIN 20e. Method of Disposition 1 Burial 2 Cremetion 3 4 Donetion 5 Other (Specifical Structure of Fineral Service Lices 11. Signature 11.	MAE PITTS  ve street and number)  & REHAB. CEN  Sex 7. Age (in yrs 95)  STER 7. Age (in yrs 95)  STER 10c. C  12. Wes Decedent Ever in Armed Forces? 1 Yes 2 2 No If Yes, Give Yeer or Detes:  ducation ade completed)  College (1-4or 5+)  VELL  (Type, Print)  NGHAM  Removel from Stete fty)  S REHAB. CEN  7. Age (in yrs 95)  10c. College (10c. s, last birthday) Yrs.  Sity, Town or Locatic BERLIN  13. Wes If Ye  16e. Decedent (Give kind Iffe. DO') DOME	al * s Decedent cas, specify C Yes 2 1 's Usual Oct of work do NOT use re ESTIC	Hours Min  21811  of Hispenic Origin? (Suben, Mexican, Puer  No Specify:  cupation  ne during most of wothred)  18. Mother's Ne	Specify Yes or Not Rican, etc.)  Methods of Biometric Specify Yes or Not Rican, etc.)  Methods of Biometric Specify Yes or Not Rican, etc.)	The second of th	9. Birthp BERU 1 Whet Cour e - Americ kk, White,	od. Inside City Limits  1 Yes 2 No  ntry?  an Indien, etc.	
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Division of Vital Reuton to the Hospital or Attending Physician: The law within 24 hours efter death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		hysician: To the best of my kr miner: On the basis of examir and manner stated.							
To the complex	29b. Signature and title of certifier	1	_	29c. Lic	ense number		29d. Date signe	d (Month,	Day, Year)
	Manue	were		+6	746257		5/12	195	
8	30. Neme and address of person who	completed cause of death (Ite	Berlin	nt), M	0 2/8	1)	17	-/-	
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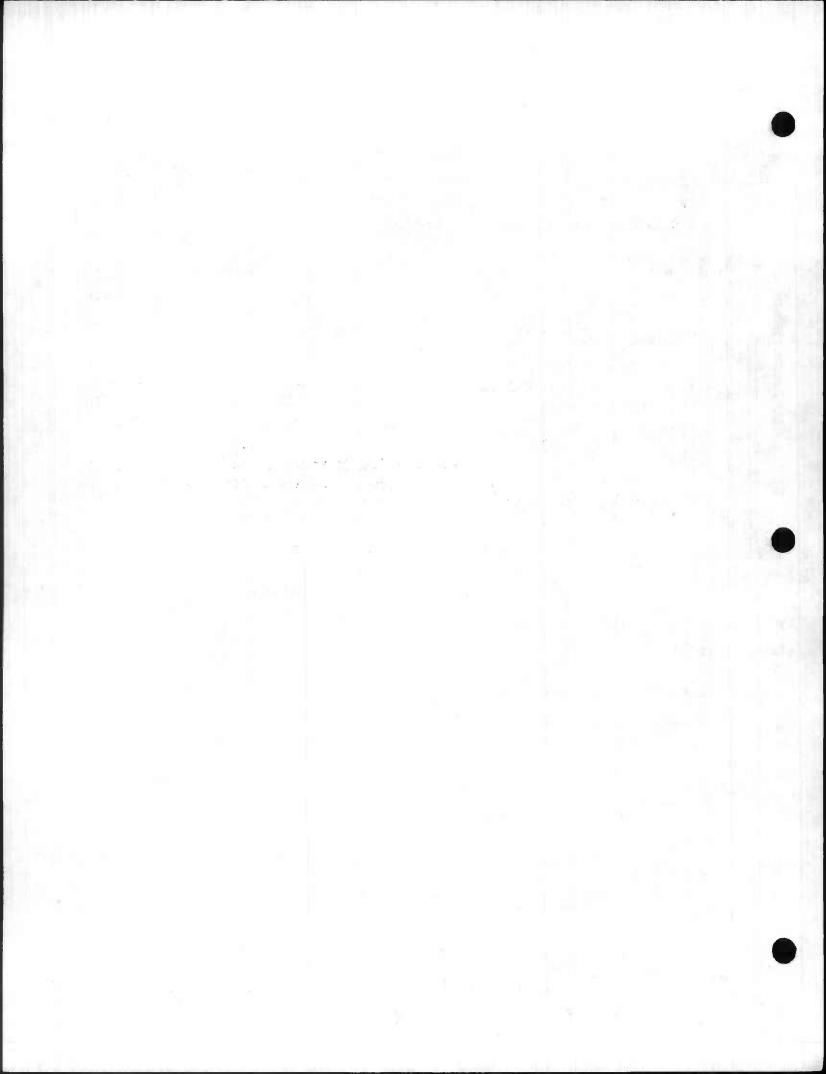


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 0:05 AM may Maria Dimitrios Prapas 16 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Union Memorial Hospital Baltimore 8. Date of Birth (Month, Day, Year) 9. Birthphate Country) Sept. 5, 1946 Greece 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplaca (State or Foraign Country) **Funeral** 10 M 20 F 52 Sept. Director 385-74-9655 Usual Residence of Deceden 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or itema 23a or 28a-f show traumatic event, the Kedical Examinar mart be notified at 1 Yes 20 No Director Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 613 Harbour Oak Road 21040 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 N Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: specify: White P 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mentel Hygiene. Important: if Nem 27 is marked other than \*n eny highty or other traumatic event, the New Botica. Elementary/Secondary (0-12) College (1-4or 5+) 12 Hairdresser Hair Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lavdanitis Aggeliki George (nmn) (nmn) Alexiou 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 613 Harbour Oak Road, Edgewood, MD 21040 Demetrios K. Prapas / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata Data 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5/19/99 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Demetrios Greek Orth. Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 234. Part I Erflar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Approximata Interval Between Onset and Death **Physician** Bowel Obstruction Small /Medical Immediata Causa (Final disease or condition resulting in death) Examiner Physician/Medical Examiner 20 Months metastatis Ovarian Cancer physicien and the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Wunknown possish CUA Division of Vital Records, þ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed ...or Vital
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2 Accident 1 Yes 2 No 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) and manner as stated. edical To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. (Check only one) 29b, Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) PKWY. Balto. MD 21218 AO-YAO 201 32. Registrer's Signature 31. Date filed (Month, Day, Year)

Registrar

State

181999



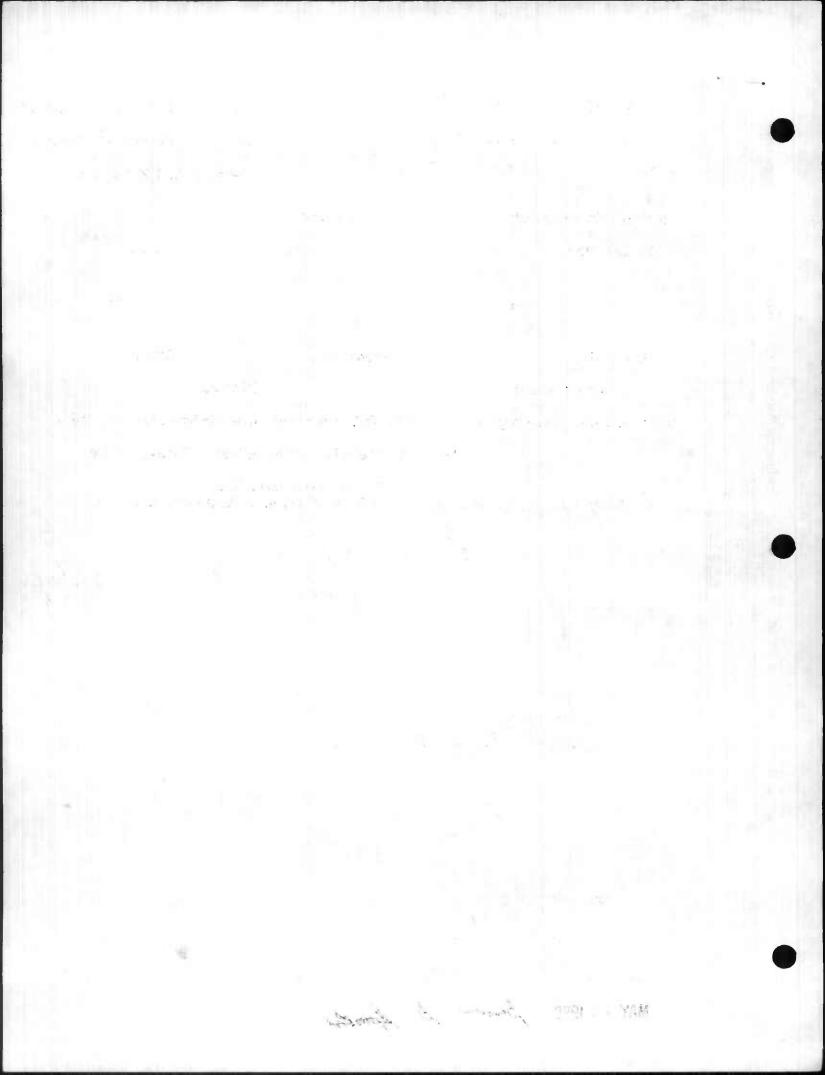
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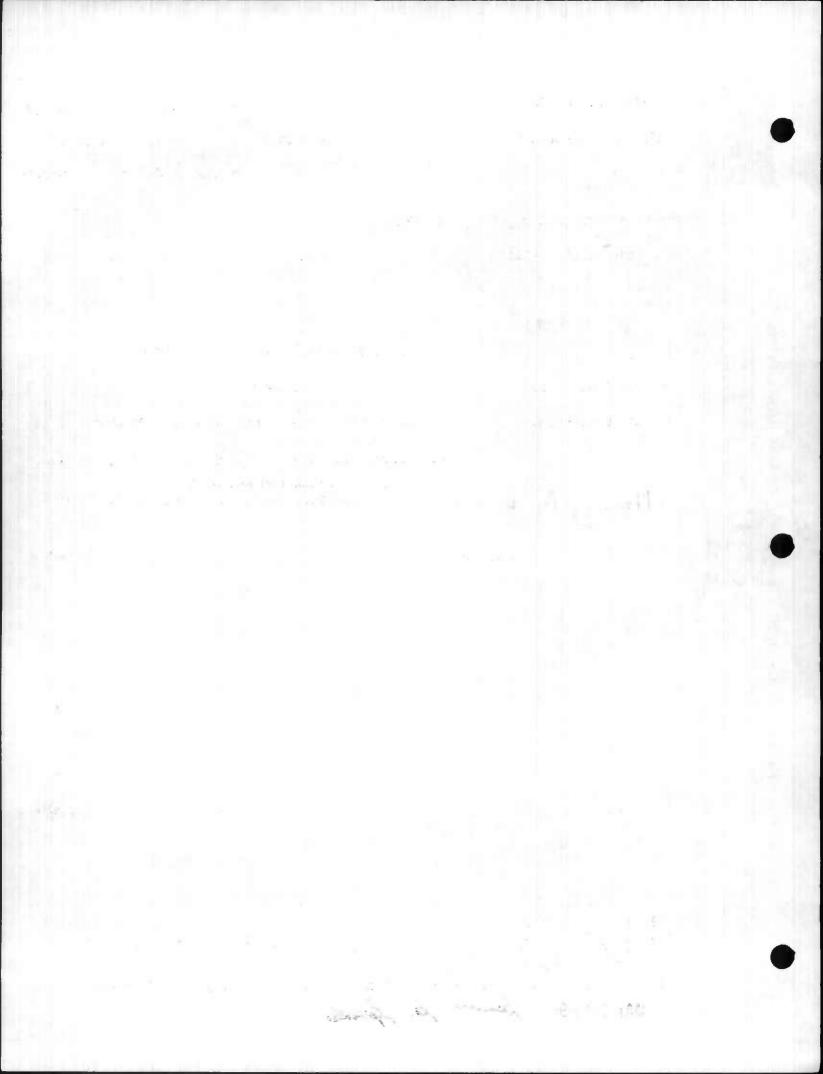
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State of Maryland / Department of Health and Mental Hygiene

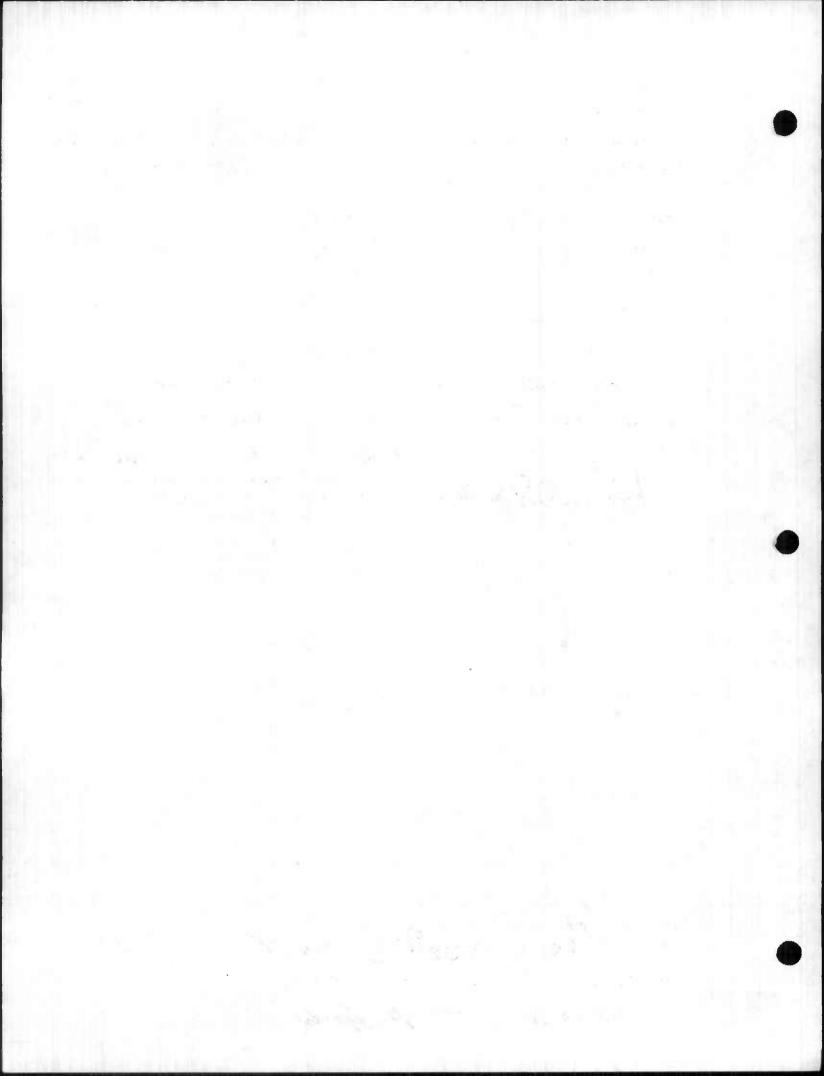
Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Death 3. Tima of Deeth Month **Physician** THELMA D. ROYER 05 06 99 1:01 pm /Medical 4a Fecility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 2418 Virginia Avenue Landover Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number Birthplece (State or Foreign Country) 7. Aga (In yrs. lest birthdey) **Funeral** Months 1□M 2X F Yrs. 49 579-66-3719 November 29, 1949 South Carolina Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10h County 10c. City, Town or Location 7 is marked other than "natural", or items 23s or 28s-f show treumsticevent, the Medical Examinar must be notified at ¥ Yes 2 No Directo Maryland Prince George's Landover 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? with 2424 Kent Village Place 20785 U. S. A. Funeral death 12. Was Dacedant Evar In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Raca - American Indian. Black, White, etc. 2 should be filed within 72 hours attar and Mental Hygiena. Is marked other than "natural", or ite 1 ☐ Yes 2 No If Yes, Give Yaer or Detes: 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Maryland 21215-0020 Specify: by Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Computer Specialist Private 12th 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Joseph Canty, Sr. Annie Marion 19e. Informant's Name/Reletionship (Type, Pnint) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is in any injury or other treun once. Ralph Royer/Husband 2424 Kent Village Place, Landover, Maryland 20785 Saltimore, 20b. Placa of Disposition (Neme of cematary, cremetory or other plece) Dete 05/11 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removel from State Ft. Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 1999 Brentwood, Maryland 21. Signature of Funarai Sarvice Licansee 32. Name and Address of Eacility UNERAL HOME Percen Nancu 7474 Landover Road, Landover, Maryland 20785 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical . Lung Cancer 9 months **Examiner** Due to (or as a consequenca of) Examiner ettanding physiclen end for usa as the bunal-trens Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es e consequence of): the death cartificate be execu Box 68760 Physician/Medical thet initiated events resulting in deeth) Last Due to (or as e consequenca of): P.O. been signed by the should be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 45€ Unknown Division of Vital Records, by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed performed 2 No 1 ☐ Yes 2 No 1 Yes Attanding Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Mother (Specify) Residence Hospital: 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No 10 28e. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how Injury occurred 28b. Time of Certification: After 5 Pending Investigation I or Attanding setter deeth. Il Director: Af 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours of To the Funeral Di completaly filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date end placa, end due to the cause(s) and menner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and placa, and due to the cause(s) and menner stated. 29a. Certifier Medical (Check only 29c. Licansa number 29d. Date, signed (Month, Day, Year) 29b. Signature 30. Neme and address of person v ted cause of deeth (Item 23a) (Type, Print) 3900 Reservoir Road, N.W., Washington, D.C. 20007-2197 Naiyer A. Rizvi, MD 31. Dete filed (Month, Dev. Yeer) MAY 1 0 1999 72. Registrar's Signeture State Registrar



State of Maryland / Department of Health and Mental Hygiene

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**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a Stata

**Funeral** 

Director

28a-f show must be notified at Director

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Completed by Funeral

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pemit. Peges 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mentel Hygiene. Important: If Itam 27 is marked other than "natural", or Hems 28a and Injury or other traumatic event, the Medical Examinations once.

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the deeth certificate be executed within 24 hours elater death.

To the Funstal Director: After this certificate has been signed by the attending physician and completely filled in by the inneati director, page 2 should be detached for use as the bune-transit

Division of Vital Records, P.O. Box 68760.

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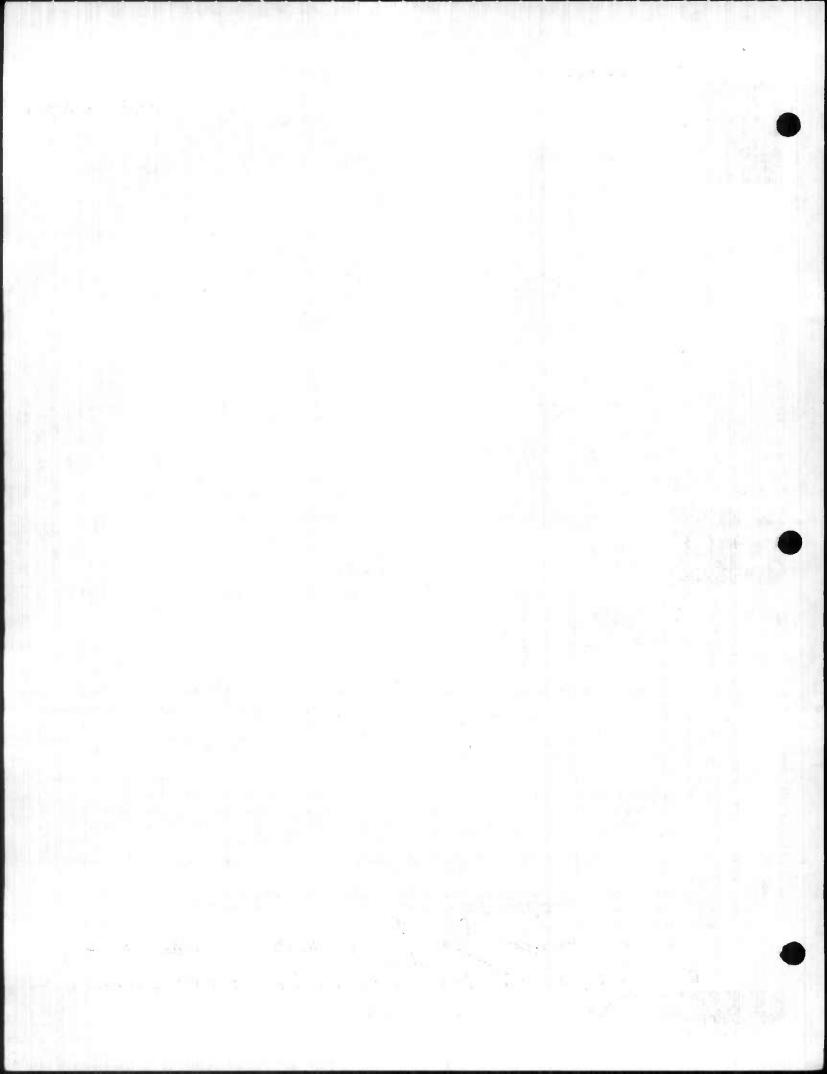
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R. Welk, M.D.
31. Date filed (Month, Day, Year)

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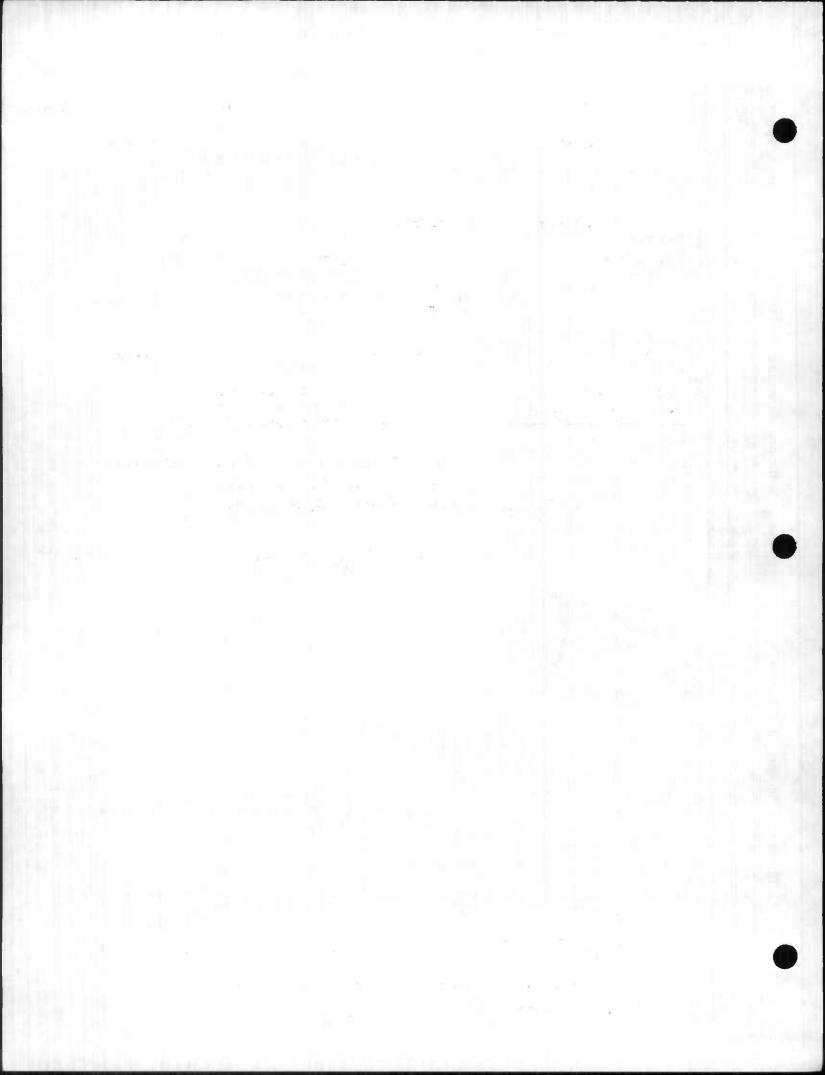


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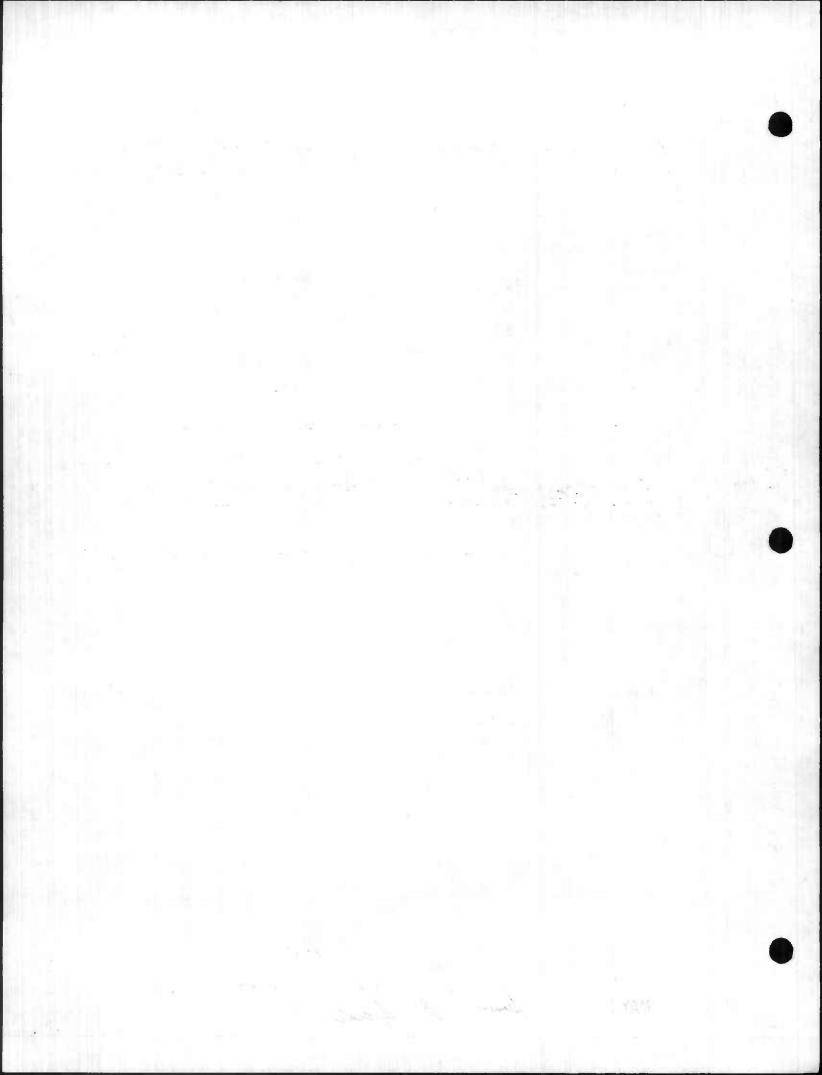
State of Maryland / Department of Health and Mental Hygiene

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nd 2 alth eath cr		Jackie R	iggleman	-Wife	Wite	73 1	LaVale	e Blv	d; LaVa	le, MD	21	502			
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permit. P Departme Importan any Injur	Department Comportant: If any Injury or once.				, O(	An 2	2. Nama a	nd Addra	ss ot Facility			Cumberland, MD			
Depa Depa Impo		21. Signature of Funerel San/loe Licensee 22. Nama and Addrass of Facility Scarpelli Funeral Home, P.A.													
		23a. Part1. Enter the disease, or complete insight coursed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line.												Approxim	atween
Physician	1				,		,		Λ					Onset an	d Death
/Medical		mmediate Ceusa diseese or condition			ovone	my a	anter	м.	disca	28			-	ione	m
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he law requires to he be been signed be age 2 should be again.	Completed									-   '			ot	mpletion of death?	of cause
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To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral Medical Cartification.	Cal Cal	29a. Certifiar (Check only one)  1 Cartifying Physician: To the best of my knowledge, death occurre and manner steled.							ne, data and pla pinion, daath oc	ce, and due to t	he cau	sa(s) and ma e and place,	annar as a	stated. o tha caus	e(s)
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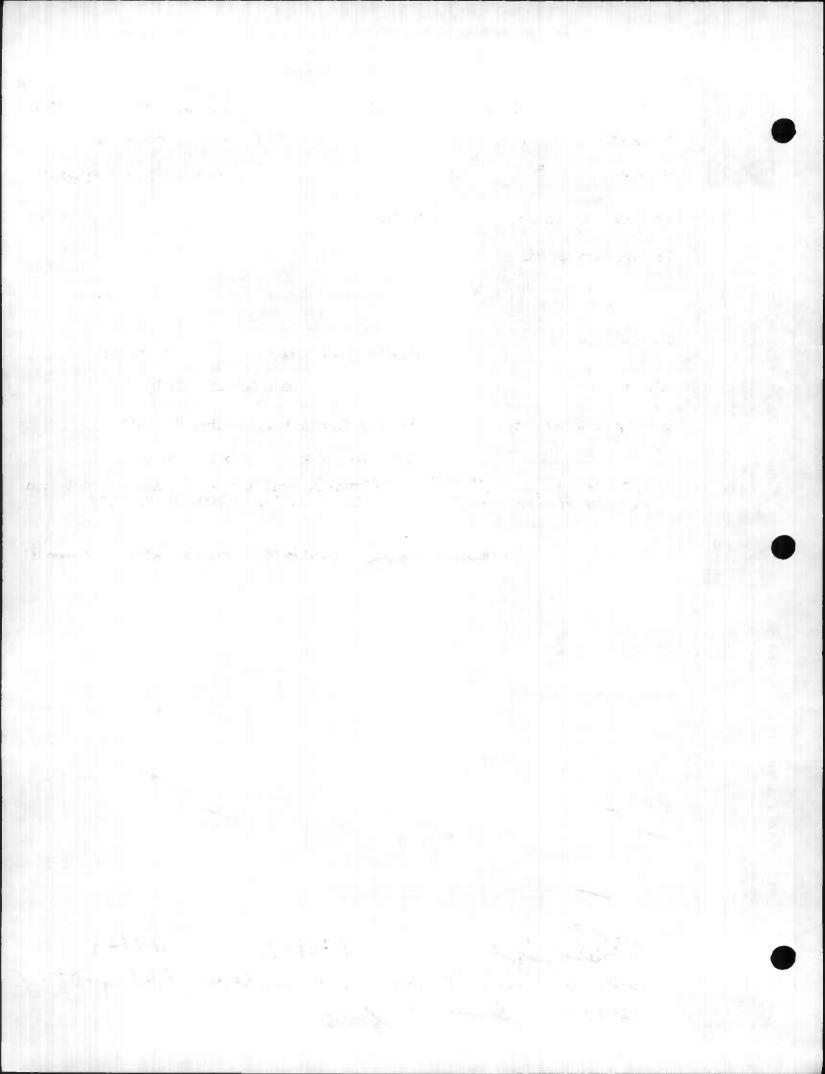
	Decedent's Name (First, Middle, La.	efl	Certi	ficate of	Death	2. Date of Dea	Reg. No.	3. Time of Death
Physician						Month	Day	Year
/Medical	David Coxe  4a Facility Name (If not institution, give		ose		lb. City, Town, or Lo	May 1	0, 1999 4c. County of	12:20 AM
Examiner	SALISBURY CENTER 5. Social Security Number 6. S	R: GENESIS ELI	s. last birthdey)	If Under 1 Year	SALISBUR If Under 24 Hrs.	V. MD	WICOM	
Director	221-44-2941 1 Usual Rasidence of Decedant	ØM 2□F 46	Yrs.	Months Deys	Hours Min.	8. Date of Birt (Month, Day January	5,1953	Delaware
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# 2A O	10e. Street and Number 8094 Brown Road			10f. Zip Code 2180	4		10g. Citizen of W USA	hat Country?
5-UUZU 72 hours after death v natural; or itsms 23s sical Examiner must sted by Funeral	11. Meritel Stetus  1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever In Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Year or Detes:		s Decedent of H es, specify Cubs	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Raca Bieck Specify:	- American Indian, , White, atc. White
mary jain L. C. C. C. C. C. C. C. C. C. C. C. C. C.	15. Decedent's Ed (Specify only highest gra Elementery/Secondery (0-12)	de completed)  Collage (1-4or 5+)	(Give kir life. DC	nt's Usuel Occup nd of work done of NOT use retired	during most of work f)	ing		co County Parks reation
o my de	17. Father's Neme (First, Middle, Last)		1 9		18. Mother's Name	e (First, Middle,		
Adental Hard of the even of th	John Andrew Ros	se			Carolyn	Coxe		
2 shot	19a. Informant's Name/Ralationship (	Type, Print)	19b. Melling	Address (Street	and Number or Run	al Route Numbe	er, City or Town, S	Stata, Zip Code)
	Ann M. Rose/Wife				Rd., Sali		MD 21804	
mit. Pages 1 s partment of Hise portant: If Nem: y injury or othe GE.	20a. Method of Disposition  1   Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify	Removal from State	Plece of Disposit cemetery, creme	tory or other plac		Data 5/15/99	Salisbu	City or Town, State
permit. Depart Importu	21. Signeture of Euneral Service Licen	T (2000	Ho		ss of Fecility Funeral H Hill RD.,			l Association
Physician /Medical Examiner	23e. Part1. Enter the disease, or composition, or heart feiture. List only immediate Causa (Final disease or condition rasulting in death)	Meraso	XF7C (or as e conseque	Cerc	nuje			Interval Between Onset and Deeth
leath certificate be executed attending physician and office use as the buriat-transit claryMedical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c	(or as a conseque					
death cert attendin d for use	Pert II Other elonificant conditions or	patributing to death but not r	esulting in the und	ertvina cause aiv	en in Pert I	23b Did 1	obacco usa con	tribute to the cause of death?
es that the death certificated by the attending be detached for use a by Physician/M.			ntributing to death but not resulting in the underlying cause given in Pert I.					3 Probably 4 Unknown
aw requir					4.5		an eutopsy rmed?	24b. Were autopsy findings available prior to completion of cause of death?
The Late he page						101	res 20No	1 ☐ Yas 2 No
ystclan: The scentificate director, pag	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Deet			
- 5 00	1 Yes 2 No  27. Manner of Death 1 Naturel 5 Panding	Hospitei: 1 ☐ Inpatient 2  28a. Dete of Injury (Month, Dey Year)	y et k?		dence 6 Otha now injury occurre			
or Attandent death Mrector: in by the	2 Accident 3 Suicide 6 Could not be 4 Homicide determined	home, ferm, stree		Yes 2 No	28f. Location (S City or Tov		er or Rural Route Number,	
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To the To the comple	29b. Signature end fittle of carrier	e number			(Month, Day, Year)			
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(JK) 10	30. Name and address of person who	1110	em 23a) (Type, Pr	int)				
			3 A A		SALISBU		21804	



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State of Maryland / Department of Health and Mental Hygiene

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eral tor	1	Social Security Number 167–07–5139	6. Set	x M 2□F	7. Age (In yrs. 81	lest birthdey) Yrs.	If Unda Months	Days	If Undar 2 Hours	Min.	8. Date of Bin (Month, Da January	th y, Year) 26,1918		plece (Steintry) OSYLV	ote or Fore
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	Oa. Method of Disposition				20b. Plece of Disposition (Neme of cematery, cremetory or other place)					Dete 20c. Location - City or Town, Stete				е	
	1 Surial 2 ☐ Cremetion 4 ☐ Donation 5 ☐ Other			State	Springhill Memory Gardens					5/14/99 Hebron, MD					
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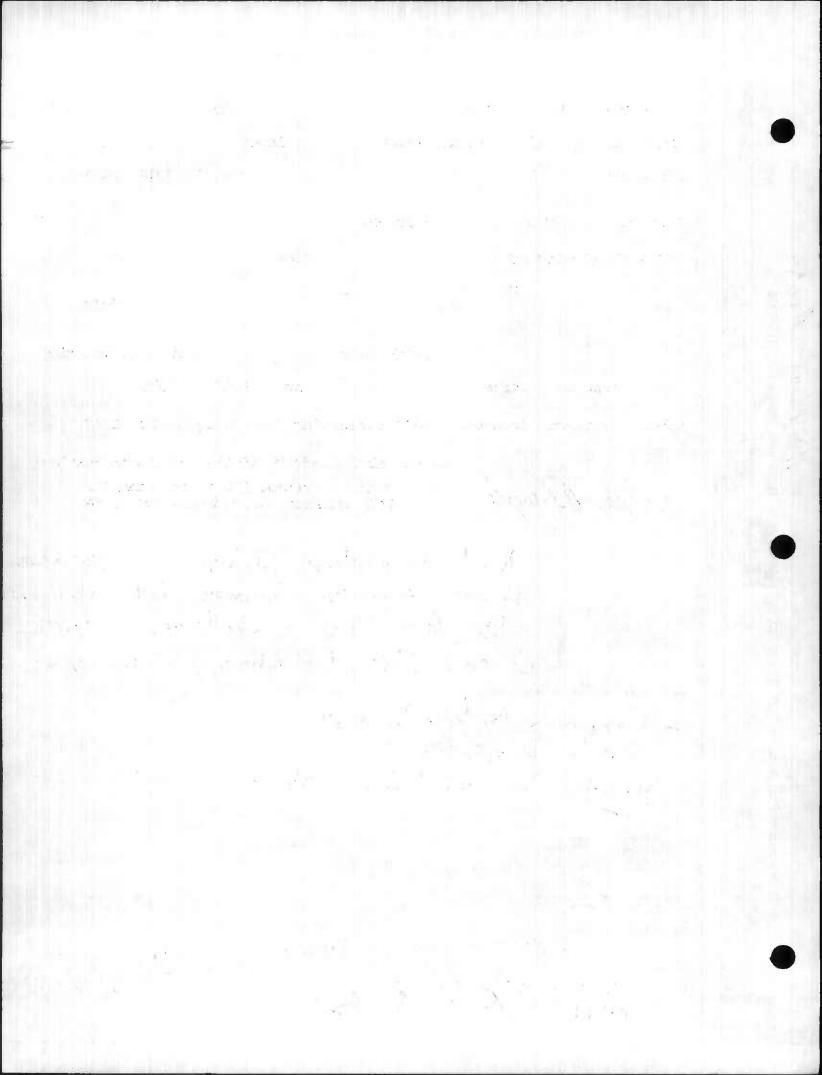


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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 2. Date of Deeth 1. Decedent's Neme (First, Middle, Last) Month **Physician** 2040 Mai HERBERT RADKE 1999 FMTT. /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Neme (If not Institution, give street and number) Examiner Lorien Nursing & Rehabilitation Center HARFOR Belcamp If Under 1 Year 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dev. Year) 6 Sex Birthplace (State or Foreign Country) **Funeral** Months Devs Hours XXM 2DF 213-05-2665 Director 82 21, 1916 Maryland Usuel Residence of Decedent 10s State 10h Counts 10c. City. Town or Location 10d. Inside City Limits itam 27 ia markad other than "natural", or hama 23a or 28a-f ahow other traumatic event, the Medical Examiner must be notthed at 1 ☐ Yes 2 No Directo Maryland Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3217 Philadelphia Road 21009 Funeral USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. NOXYes 2 No If Yes, Give Year or Detes: WW II 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 20No Specify: p 3€Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within.
Department of Health end Mental Hygiene.
Important: If ham 27 I a marked other than "n any injury or other traument. Eiementery/Secondary (0-12) College (1-4or 5+) Brick Layer Steel Manufacturing 6 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Radke (u/k)(u/k)Carl Augustas Eva 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Helen E. Morrison - Daughter 3217 Philadelphia Road, Abingdon, MD 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, Stete 1 XBurlal 2 Cremation 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 5/13/99 Baltimore, Maryland New Cathedral Cemetery 22. Name and Address of Fecility 21. Signeture of Funeral Service Licens Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 23a. Part . Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one muse on each line. Approximete Intervel Between Onset and Deeth Physician /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) Examiner Examiner reumonia hysicien and the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest physicien Physician/Medicai as Industy Asease 980 23b. Did tobacco use contributa to the causa of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. ed by the a P.O. 1 468 2 No 3 Probably 4 Unknown signed by by Records, 8 24b. Were eutopsy findings available prior to 24e. Wes en eutopsy Completed completion of cause of deeth? has 20 No 1 Yes 2 No L CUVVEN Division of Vital 25. Wes case referexeminer? 26. Plece of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitei: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpetient 3 DOA 28d. Describe how injury occurred 27. Menner of Death 28h. Time of 28c. Injury et Work? Certification: 28e. Dete of Injury (Month, Day Year) Aftert 1 Naturet 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after daat Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 6 Tertifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) and menner es stated.

| Medical Examiner: To the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end pleca, end due to the cause(s) and menner stated. 29e. Certifier (Check only one) 2 Medical Exag To the F within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifie 29c. License number 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) NME State

Registrar



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Deeth 1. Decedent's Nema (First, Middla, Last) Dey Month Charles Webster Rodgers Arpil 30, 1999 6:15 a.m. 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 170 Bannister Street Aberdeen Harford If Under 1 Yaar 8. Date of Birth (Month, Dey, Year) 5. Sociel Sacurity Number 7. Aga (In yrs. last birthdey) Birthplece (State or Foreign Country) Min. Hours 18 M 2□ F Months Deys 370-20-7271 Yrs. 71 May 11, 1927 Michigan Usuel Residence of Deceden 10c. City, Town or Location 10d. Inside City Limita 10e Steta 10h County 1 X Yas 2 □ No Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 170 Bannister Street U.S.A. 14. Race - American Indien, 21001 12. Was Decedent Ever in U.S. Armed Forcas? 1 \$\text{SYes} & 2 □ No If Yes, Give Yeer or Datas: 1945-48 Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puarto Rican, etc.) Bieck, White, etc. 1 Never Merriad 2/2 Married Specify: White 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) Supply Clerk Business 18. Mother's Name (First, Middle, Meiden Surname) 17. Fether's Neme (First, Middle, Last) Mabelle Collier Edgar G. Rodgers 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. informent's Neme/Reletionship (Type, Print) Dolores Rodgers (Spouse) 170 Bannister St., Aberdeen, Maryland 21001 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State ©Burlel 2 ☐ Cremetion 3 ☐ Removei from Steta St. Johns Cemetery 5/5/99 4 ☐ Donation 5 ☐ Other (Specify) Hydes, Maryland 21. Signature of Fungral Service Licensee 22. Neme end Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate intervei Between Onset and Deatl Immediete Ceuse (Finel disease or condition resulting in deeth) Due to (or aa e consequence of): Due to (or as a consequence of) 23b. Did tobacco uea contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 12 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 Yea No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Plece of Deeth (Check only one)

**Physician** /Medical Examiner Examiner

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98 esn Po

signed by the a

this certificate has ral director, page 2

funeral

Physician/Medicai

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Completed

Be

Certification: To

Medical

The law requires that the death certificate be executed

Attending Physician:

Division of Vital Records, P.O. Box 68760,

marles

**Physician** 

/Medical

Examiner

Director

Funerai

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Completed

**Funeral** 

Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "naturel", or items 23s or 25s-4 show eny injury or other traumatic event, if a Medical Examiner must be notified a

Baltimore, Maryland 21215-0020

Sequentielly list conditions, if eny, leeding to immediate cause. Enter Undarfying Cause (Disease or injury that initiated events resulting in death) Last

exeminer? 1 Yes 2 No 27. Manner of Deeth

5 Pending investigation

28e. Dete of injury (Month, Dey Year) 28b. Time of

1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Spacify) 28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

28d. Describe how injury occurred

29a. Certifier (Check only one)

1 Neturel

2 Accident

3 Suicide

4 ☐ Homicide

Certifying Phyelcian: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(a) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signeture end title of certifier

6 Could not be determined

29c. License number

29d. Date signed (Month, Dev. Year)

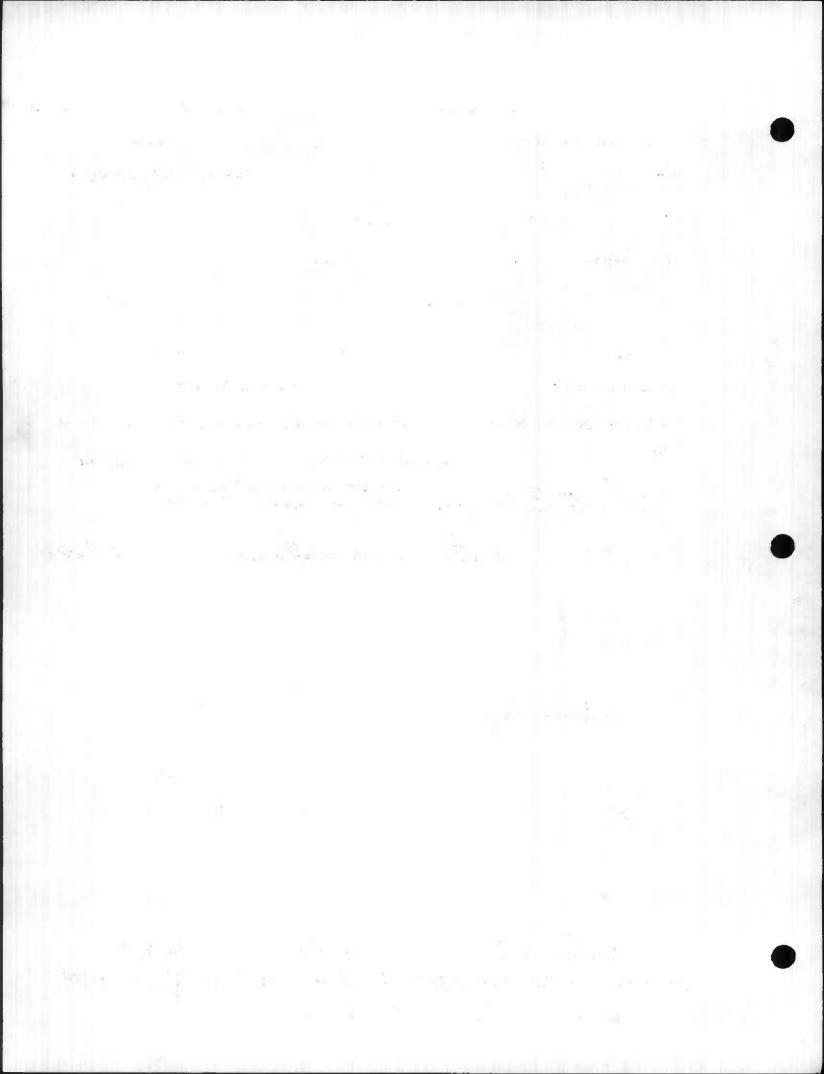
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To the Hospital or Attendit within 24 hours efter death. To the Funeral Director: A completely filled in by the fu

who completed cause of deeth (Item 23e) (Type, Print) Neme and eddress of person CHICLES 219W.BEL ECK TO

State Registrar 31. Dete filed (Month, Dey, Yeer) MAN 3

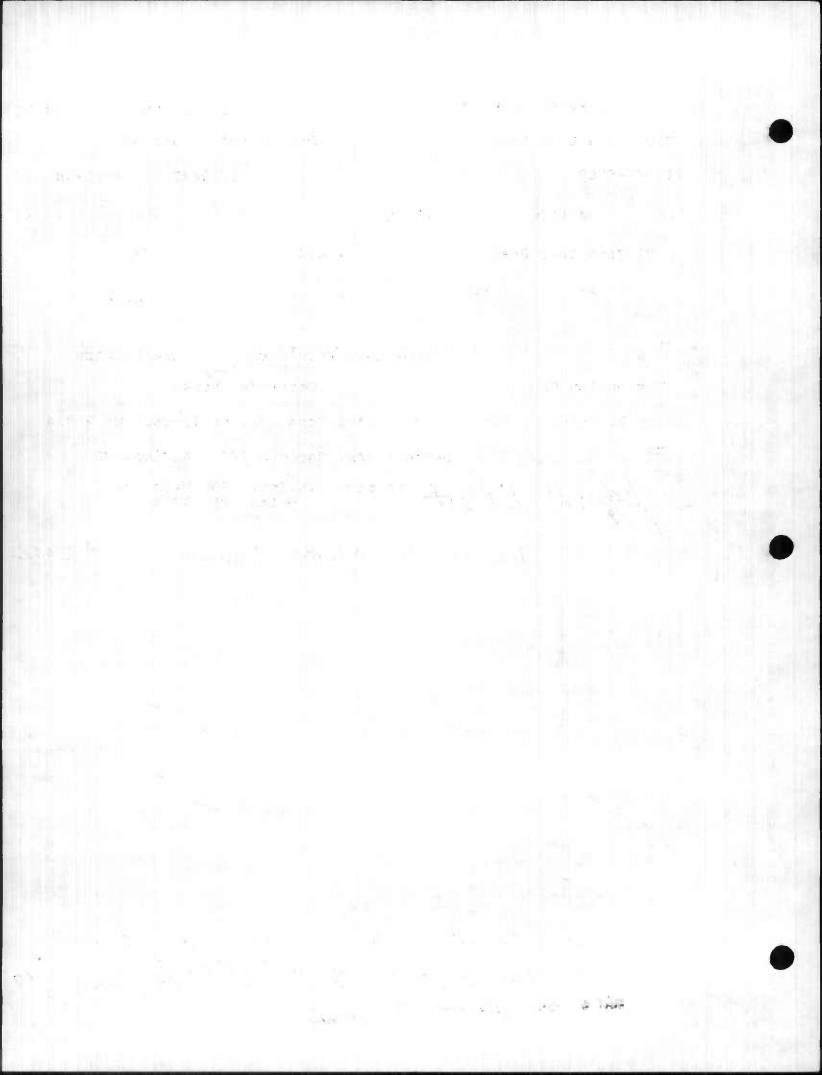




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State of Maryland / Department of Health and Mental Hygiene

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#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) May 8, 1999 10:00 AM CLYDE F. REED 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Name (If not Institution, give street and number) Havre de Grace Harford Harford Memorial Hospital If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Dev. Yeer) Days XXM 2 F Yrs. 213-18-2244 N. Carolina 4/30/1918 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2□No Darlington Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21034 USA 1222 Main Street Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien. 12. Was Decedent Ever In U,S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 1 100 If Yes, Give Year or Dates: 1 □ Never Married 2 □ Merried 1 Yes 2KINo Specify: Specify White 3 Nidowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Education 4 Teacher 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Crumb E. Lucy C. Reed Herbert 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. informant's Name/Relationship (Type, Print) Lucy L. Hardcastle- daughter 3648 Mill Green Rd., Street, MD 21154 20b. Place of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removel from State R.A. Ferris Crematory 5/10 West Chester, PA 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility 600 Main ST. Harkins Funeral Home, Inc., Delta. Enter the disealle, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Delta, PA 17314 Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting In death) Due to (or as e consequence of): Due to (or as e consequenca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 24b. Were autopsy findings eveilable prior to 24a. Was an autopsy completion of cause of deeth? 26. Place of Death (Check only one)

**Physician** /Medical Examiner

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**Physician** 

/Medical

**Examiner** 

Director

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**Funeral** 

Director

item 27 is marked other than "natural", or items 23s or 28s-f show other treumstic event, the Medical Examinar mast be noursed at

"natural"

Pages 1 and 2 should be fill ment of Health end Mental H ant: If item 27 is marked off

6 Department of Important: If any Injury or pace.

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Examiner physician and the buriel-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical use as t

25. Wes case referred to medical exeminer? 2DNo 1 Yes Manner of Death

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital:

1 Denpatient 2 ER/Outpatient 3 DOA 28b. Time of

Other: 4☐ Nursing Home 5☐ Residence 6 ☐ Other (Specify) 28c. Injury et Work? 1 Yes 2 No

28d. Describe how Injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier

Neturel Accident

3 Suicide

4 Homicide

Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and manner stated.

29b. Signiture

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29c. License number

29d. Date signed (Month, Day, Year)

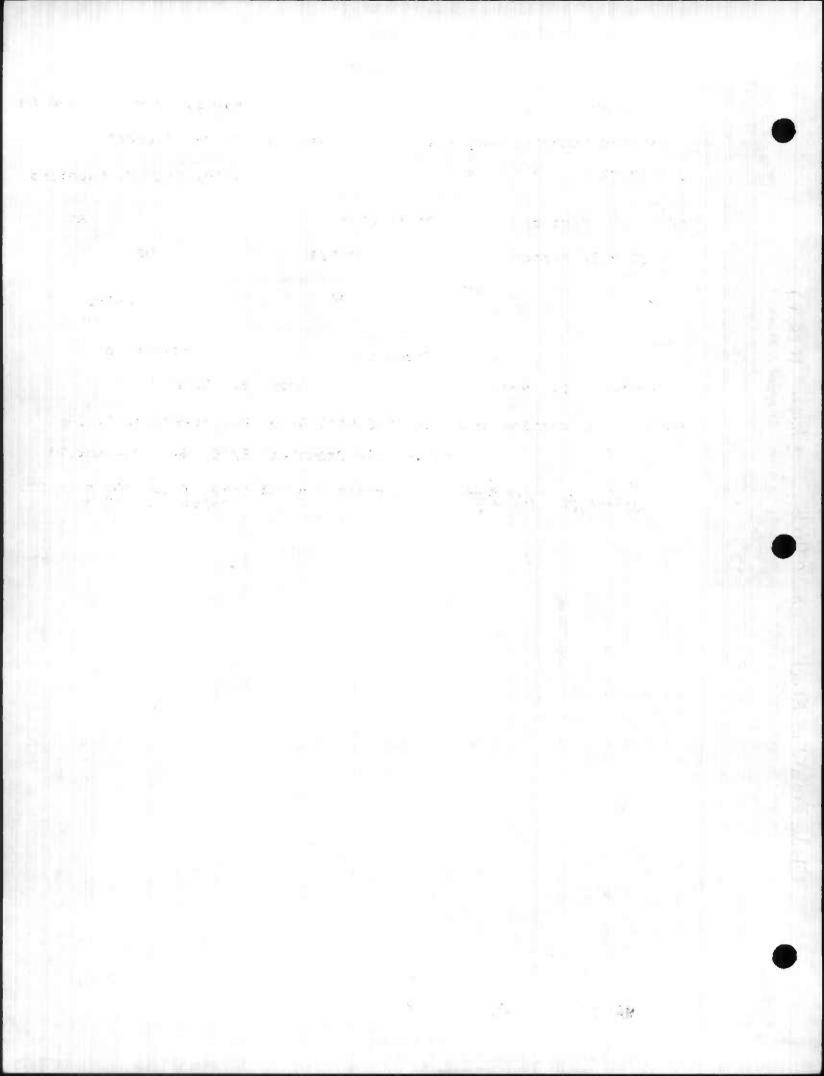
State

31. Dete filed (Month, Day, Year) MAY 1 0 1255

10 32 Registrer's Signature

completed cause of deeth (Item 23a) (Type, Print),

Registrar



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State of Maryland / Department of Health and Mental Hygiene

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/Medical		CARLTON			4-1				b. City, Town,		1AY	05,1	9907	2110	)
Examiner		me (If not institut			nber)				JPPER			4c. County		TANCOC	
-	5. Social Secu	yceton vity Number	6. Sex		7 Age (In ure	. last birthday)	If Under	r 1 Year	If Under 24					FORGES	
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					ertificate		Death	F	leg. No.		7916		
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Examine		4a Facility Nama (If not institution, giva	street and number)			4	lb. City, Town, or Lo	cation of Deeth	4c. County	of Death			
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inyland show		Usual Rasidence of Decedent  10a. Stata 10b. County		10c. City, Town o	r Location					10	od. Insida City L		
W I	Director	Maryland Prince G	eorge's	Lanha	m						1 X Yes 2		
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23a	a	9007 Hickory Hill	Avenue			207	06		U.S.A	•			
pennit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Depmit. Segon 1 and 2 should be filled within 72 hours after death and Mential Hygiens important: if Item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other treumstic event, the Medical Exercites must be noticed at ODEs.	by Funeral	11. Maritef Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Wes Decedent E Armed Forces? 1 ☐ Yas 2 ☑ N If Yas, Giva Yeer or Detas:	evar in U,S.	3. Was Decede If Yes, specif	fy Cuba	ispenic Origin? (Spe an, Maxican, Puarto Specify:	cify Yas or No- Rican, atc.)	Biac	e - America k, Whita, a Whit	itc.		
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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Alice Sanders 1:00 ma 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street and number) Hospital Washington Adventist TA Koma PALK Montgomery 7. Age (In yrs. last birthday)
Yrs. 5. Social Security Number ff Undar 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Days 1□ M 2 F Months Hours 579 38 3710 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Prince Georges HyAttsville 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? ROAD Beechwood 20783 3110 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, Whita, atc. 11. Maritai Status 1 Never Married 2 Married 1□ Yes 2♥ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Aide Pastor's 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ohn JACKSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sanders SAME 20b. Place of Disposition (Name of cematery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Bunial 2 □ Cremation 3 □ Removal from State NAtional MARYland 14 MAY 99 LAurel 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses GREENE FUNERAL HOME nelson & Greene 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac prespiration area, 22314 shock, or heart failure. List only one cause on each line. Approximate Interval Between HYPOTENSION Immediate Ceuse (Finel disease or condition resulting in death) Due to (or es e consequence of): Sticuc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): ltiple Ab Cess Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 3□ No Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how Injury occurred 27. Menner of Deeth 28a. Date of tnjury (Month, Day Year) 28h Time of 28c. Injury et Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, straet, factory, office building, atc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

the attending physician and hed for use es the burial-transit Division of Vital Records, after death.

Director: After this certific

Physician/Medical þ Completed 2

**Physician** 

- /Medical

Examiner

Director

Funeral

þ

Completed

Director

item 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, it a Medical Examiner must be northed at

permit. Pages 1 and 2 should be filed within 72 hours effer a Department of Health and Mental Hygiene. Important: If Nem 27 is marked other than "natural", or Nem any Injury or other traumetic event, it as Medical Exercises page.

Physician

/Medical

Examiner

Examiner

To the Hospital within 24 hours To the Funerel Hospital

Registrar

edical

(Check only one)

29b. Signature and title of of rtifier

Rushid

MAY 1 0 1999

t Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Mh

29c. License number 12 39

29d. Date signed (Month, Day, Year) Mux 6 TH

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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Year **Physician** 1999 May 10, 6:00 P.M. Richard R. Smith /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, giva street and number) 4c. County of Death **Examiner** Prince George's Suitland 3211 Randall Rd. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 1 ☑ M 2 ☐ F Birthplace (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) Yrs 65 Sept. 214-28-9092 3, 1933 Maryland Usual Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland Prince George's Suitland 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20746 3211 Randall Rd. Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - Amarican Indian, Biack, White, atc. 11. Marltai Status 1 ☐ Never Married 2 ☐ Married Specify. White 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Painting - Decorating Painter 17. Father's Name (First, Middla, Last) 18. Mothar's Name (First, Middle, Maiden Surname) Nellie J. Smith Richard E. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3213 Randall Rd. Suitland, MD 20746 Jennielee Hill-Gatt 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 X Burial 2 ☐ Cremation 3 ☐ Ramoval from State 5/14/99 Suitland, Maryland Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signaturn of Funeral Service Licen 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon Hill, MD 20745 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, List only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure Approximate fntarval Batween Onsat and Death Immediate Cause (Final BRONCHOALUEOLAR CARCINOMA PROBA BLK diseasa or condition resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or injury that initiated events resuiting in death) Last Dua to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part I. 23b. Dfd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown WALL MYOCARDIAL INFARCTION INEGRIOR þ 24b. Ware autopsy findings available prior to completion of cause of death? PREUMONIA Completed 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examinar? Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Anasidance 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Cartifier the Certifying Physician: To the best of my knowledga, death occurred at the tima, date and place, and due to the cause(s) and manner as statad.

| Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29c. License number 29b. Signature and title of certiflar 29d. Date signed (Month, Day, Year) 136091 30. Name and address of person who completed cause of death (I) 23a) (Type, Print) OLD BRANCH AVE. TEMPLE HILLS BOAKYE ANTHONY MA 6104

Registrar

31. Data filed (Month, Day, Year)

MAY 1 3 1999

32. Registrar's Signature

After

filled in by the

Hospital or Attending
 24 hours after death.
 Funeral Director: After

To the Hospital of within 24 hours at To the Funeral D completely filled I

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show trsumstic event, the Medical Examiner must be recitied at

permit. Peges 1 and 2 should be filed within 72 hours effer to Department of Heelih and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ther any injury or other traumatic event, the Medical Exami

**Physician** /Medical

Examiner

signed by the attending physician and d be detached for use as the burial-transit

Records.

Division of Vital

the Maryland

death

**DHMH 16 Rev 6/95** 

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THE REPORT OF THE PROPERTY OF

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Physicia		1. Decedent's Name (i	First, Middle, Las	st)				2. Dete of Death	Day V	3. Time of Death
. /Modie	_	Stanle	ey S	. S	cott			May 10	, 1999 Teer	10:30am
· /Medica Examine		4a Facility Neme (If no 3103 Hill			er)		4b. City, Town, or Lo		4c. County of Dee Prince G	
Funeral		5. Sociel Security Num	ber 6. S	ex 7.	Age (In yrs. lest birt	hdey) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9 Bir	0
Director		577-24-050	"	ĎM 2□F	81	rs. Months Days	Hours Min.	Aug. II,	1917¢a1v	thplece (State or Foreign ountry) ert Cty. M
Post I			0b. County		10c. City, Town	or Location				10d. Inside City Limi
Sa-I	o o		Prince G	eorge's	Cheve	1				1₫Yes 2□N
3e or 2		3103 Hills				10f. Zip Code 2078	35	109	United S	
	Ē	11. Meritel Stetus  1 Never Merried  3 Wildowed 4		12. Wes Decede Armed Force 1 2 Yes 2 If Yes, Give Year or Date		13. Was Decedent of H If Yes, specify Cube 1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \)	tispenic Origin? (Spe en, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Bleck, Whit Specify: B1	te, etc.
tal Hygiene "natural", or other than "natural", or event, the Medical Exam	Completed by	(Specify Elementary/Seconds	5. Decedant's Ed only highest gra	lucation de completed) College (1-4		Decedant's Usuel Occup (Give kind of work dona life. DO NOT use retired	during most of worki	ing 10	6b. Kind of Business	/Industry
Hygiene. ort, the M	S	12			F	ostal Clerk			ederal Go	vernment
la de la	Be	17. Father's Neme (Fir Earl Scot					18. Mother's Name	ones	alden Sumeme)	
h and Mental I	2	19e. Informant's Neme		Type, Print)	19b.	Meiling Address (Street			City or Town, State,	Zip Code)
riment of Health rament of Health njury or other tr	Anita Mo 20e. Method of Dispos 1 Buriel 2 0 4 0 Donetion 5	ition Cremetion 3 🗆	Removel from Ste	20b. Plece of cematar	03 Hillside Disposition (Name of y, crametory or other pleases) Lincoln Ceme	ce)	Dete 20	aryland Oc. Location - City or rentwood.		
physicien end british staminer  edical Examiner	23e. Pent: Enter the shock, or haert for shock, or haert for the shock or haert for disease or condition resulting in deeth)  Sequentially list condition for the shock of the	eei		rebrova	consequence of):  8 C L (2 / Consequence of):	accurle, desease		11,	Approximate Interval Between Onset and Deeth	
physicie s the bur		that initiated events resulting in death) Las	at							1
e attending physicie	8	resulting in death) Las		d	h but not resulting In	the underlying cause glv	ven in Part I.	23b. Did tob	acco use contribut	e to the cause of dea
e attending physicie	Physician/Medi	resulting in death) Las			h but not resulting In	the underlying cause gh	ven in Part I.			
igned by the attending physicie be detached for use as the bur	by Physician/Medi	resulting in death) Las			h but not resulting In	the underlying cause gh	ven in Part I.		autopsy 24b.	Probably 4 🗆 Unkn
ate has been signed by the attending physicie page 2 should be detached for use as the bur	Completed by Physician/Medi	resulting in death) Las	nt conditions of		h but not resulting In	the underlying cause gh		1 Ves	autopsy 24b.	Probably 4 Unkn
his certificate has been signed by the attending physicie al director, page 2 should be detached for use as the bur	To Be Completed by Physician/Medi	Pert II. Other significa  25. Wes case referred exeminer?  1 Yes 2 No.	nt conditions of	Hospital: 1 ☐ Inp 28a. Dete of (Month,	atient 2□ ER/Ou Injury 28b. T	tpetient 3□ DOA Ott	26. Place of Deetl ner: 4 □ Nursing Ho	1 Yes	autopsy 24b.  autopsy 24b.  2 Sho	Probably 4 Unkn  Wara autopsy finding eveilable prior to completion of cause of death?  1 Yes 2 No
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in 24 fours after death.  The funer of Director: After this certificate has been signed by the attending physicis pleasing filled in by the funeral director, page 2 should be detached for use as the burners.	ledical Certification: To Be Completed by Physician/Med	25. Wes case referred exeminer? 1   Yes   2   No No   27. Manner of Deeth 1   Naturel   2   Accident   3   Suicide   4   Homloida   29e. Certifler (Check only one)	nt conditions of	Hospital: 1 Inp 28a. Dete of (Month,) 28e. Plece of building	Dey Year)  Injury - At home, far, etc. (Specify)  set of my knowledge of examination end	tpetient 3 DOA Offine of Jacob Injury M 1 mm, street, factory, office	26. Place of Deetliner: 4 Nursing Hory et rk? Yes 2 No	24a. Was an perform  1  Yes  1 Yes  1  Yes  24  Yes  1  Yes  24  Yes  25  Yes  26  Yes  27  Yes  28  Yes  28  Yes  29  Yes  29  Yes  29  Yes  20  Yes  20  Yes  20  Yes  20  Yes  20  Yes  20  Yes  20  Yes  20  Yes  20  Yes  20  Yes  21  Yes  22  Yes  23  Yes  24  Yes  25  Yes  26  Yes  27  Yes  28  Yes  29  Yes  20  Yes  2	autopsy 24b. autopsy 24b. 2 SNo 2 Other (Springly occurred vinjury occurred state) aset and Number or F State)	Wara autopsy finding eveilable prior to completion of cause of death?  1 Yes 2 (No ecity)  Rural Route Number, as stated. In the cause(s)

DHMH 16 Rev 6/95

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

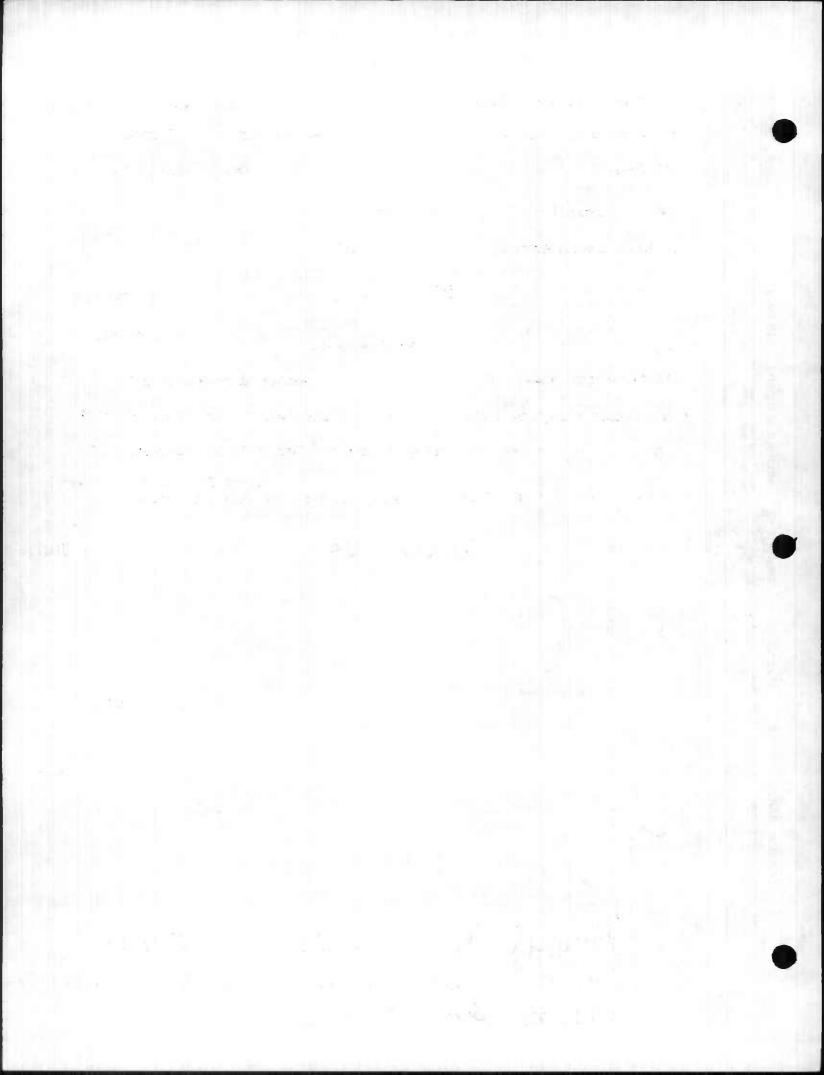
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) 13<sup>Dey</sup> 1999 **Physician** Francis Duvall Shaughney May 3:20pm /Medical 4e Fecility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 44 Pennsylvania Avenue Westminster Carroll If Under 1 Year If Undar 24 Hrs. 8. Date of Birth (Month, Dey, Year) Oct 26 1929 Birthplece (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 MM 2□ F 212-38-0055 69 Yrs. Pa. **Director** Usuel Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours effer death with the Merylen Department of Health end Mentel Hygiene. Important: If item 27 is marked other than "naturel", or flems 23s or 28a-f ehow any fujury or other treumetic event, the Medical Evantine must be notified at once. 10a. Stela 10b. County 10c. City, Town or Location 10d. Inside City Limits Md Carroll Westminster 1 Yes 2 □ No Directo 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 44 Pennsylvania Avenue 21157 USA Funeral 12. Wes Decedant Ever in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian. 11. Merital Status 1 X Yas 2 No 1947— If Yes, Give Yaer or Detes: 1953 1 ☐ Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) State of Md. Elamantary/Secondery (0-12) College (1-4or 5+) HVAC mechanic 17. Fether's Name (First, Middle, Last) Francis Joseph Shaughney 18. Mothar's Name (First, Middle, Maiden Sumeme) Jennie Elizabeth Duvall 19a. Informent's Name/Reletionship (Type, Print)
Grace Mercer Shaughney (spouse) 19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 44 Pennsylvania Ave., Westminster, Md 21157 20b. Plece of Disposition (Neme of 20c. Location - City or Town, State 20e. Method of Disposition Wesley Freedom Cemetery 5-17-99 1 ☑ Buriel 2 ☐ Crametion 3 ☐ Removel from Stete Eldersburg, Md 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funarel Sarvica Licansee Paige Haigh bert P.O. Box 195 Sykesville, Md 21784 23a. Pert1. Entar tha diseese, or complications that causad the death. Do not enter the mode of dying, such as cardiac or raspiretory errest, shock, or haert failure. List only one cause on aech lina. Approximate Intervel Between Onset end Deeth Physician WUNG Immediate Ceusa (Final disease or condition resulting in death) /Medical me. Examiner Dua to (or as a consequence of). Examiner ettending physicien end for use es the buriel-transit requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physiclan/Medicai Due to (or es e consequence of): 80 signed by the aid be deteched for 23b. Did tobacco use contributs to the cause of death? P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was en eutopsy performed? Completed page 2 s certificate has 1 ☐ Yes 2 ☐ No 2 3-NO Hospital or Attending Physician: 25. Was case raferred to medical examiner? Be 26. Placa of Daath (Check only ona) Other: 4 Nursing Home 5 Hesidanca 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 6 ☐Othar (Specify) After this funeral 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how Injury occurred Certification: 5 Pending Investigation 1 Naturel 24 hours efter deeth. 1 ☐ Yes 2 No 2 Accident 6 Could not be datermined Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Sulcide 28e. Pleca of Injury - Al home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide 29e. Cartifian edical Certifying Physician: To tha best of my knowledga, daath occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar stated. (Check only one) within 2 To the 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signature a 0 30. Nama and addrass of person who completed cause of deeth (Item 23e) (Type, Print) lashington beight, Westmirretr, MD 21157

224

32. Registrar's Signature

m.D

State Registrar 31. Dete filed (Month, Day, Yaar)



State of Maryland / Department of Health and Mental Hygiene

3. Time of Death

			Certifica	te of	Death		Reg. No.			
Physician Medical Examiner	1. Decedent's Neme (First, Middle, La Elizabeth Mar	garet Smith				2. Dete of De Month 1		98er	3. Time of Death 3:15pm	
	4e Facility Neme (If not Institution, giver Carroll County Ge	eneral Hospital			46. City, Town, or Lo Westminst		4c. County Carro	y of Death		
Funeral Director		Sex 1□ M 21XF 7. Age (In yrs. 60	Yrs. If Under Months	Deys	If Under 24 Hrs. Hours Min.	8. Dete of Bir (Month, De Jan 7	1939	9. Births Cour Md.	olece (State or Foreigntry)	
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ner deem with the mar therm 23s or 28s-f si her must be notified Funeral Director	10e. Street end Number 6616 Monroe Avenu	ie	10f. Z	ip Code 2178	34		10g. Citizen of USA	Whet Cour	ntry?	
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as 1 and 2 should be filed of Health and Mental Hyg (16 Health and Mental Hyg (16 Health and Mental Hyg (16 Health and 16 Health	15. Decedent's E (Specify only highest grant properties) Elementary/Secondary (0-12)		16a. Decedent's Usi (Give kind of w life. DO NOT homema	ork done use retire	pation during most of work d)	ing		6b. Kind of Business/Industry  domestic		
	17. Fether's Neme (First, Middle, Last) George Sauerhoff  18. Mother's Neme (First, Middle, Maiden Sumeme) Fannie P. Decker									
	19a. Informent's Neme/Reletionship (Type, Print) William Henry Smith Jr. (spouse)  19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete 6616 Monroe Ave., Sykesville, Md 21784									
	20e. Method of Disposition  1X Burial 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify)  20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca)  Loudon Park Cemetery  5-18-99  Baltimore, Md									
Department Department Important: I any injury o pncs.	21. Signature of Funeral Servica Licer	Herbert			ess of Fecility Ha 95 Sykesv				Chapel	
hysician	23a: Pert1. Enter the diseese, or com shock, or heart feilure. List only		etions thet caused the deeth. Do not enter the mode of dying, such as cardiac of ecause on each line.						Approximate Intervel Between Onset and Deeth	
/Medical xaminer	Immediate Ceuse (Finel disease or condition resulting in death)	e Sepsi	sr es e consequence of	):					1 day 2 week	
attending physician and for use as the buniel-transit clary. Medical Examiner	Sequentielly list conditions, if any, leading to immediate a social positions of the social to immediate a social to immediate a social to immediate a social to immediate a social to immediate.									
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hes been signed by the ge 2 should be deteched mpleted by Physical	Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I.  23b. Did tobacco use contributing to deeth but not resulting in the underlying cause given in Pert I.									
		10103(5				24e. Wes en autopsy performed?			ere eutopsy findings alleble prior to empletion of cause death?	
	25. Wes case referred to medical examiner?				26. Plece of Deet	h (Check only	Yes 2□No one)		PYes 2□ No	
Z Sig	1 ☐ Yes 2 ☑ No	Hospitel: 1 Impatient 2	ER/Outpatient 3 0	OA O	her: 4 Nursing Ho	me 5□Res	Idence 6 🗆 Ot	her (Speci	(y)	
Aftar fune fune fior	27. Manney of Deeth  1 Neturet 5 Pending  2 Accident investigation		28b. Time of Injury M		Yes 2 No		how injury occu			
	3 Suicide 4 Homicide  3 Suicide 4 Homicide  4 Homicide  4 Could not be determined  28e. Plece of injury - At home, farm, street, fectory, office building, etc. (Specify)					28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)				
Nospital or Atten n 24 hours aftar deet to Funeral Director: pletely filled in by the edical Certifica		nyalcian: To the best of my kno niner: On the basis of examine end manner steted.								

200 Memorial Ave. Westminster, MO

29d. Date signed (Month, Dey, Year)

State Registrar

31. Dete filed (Month, Dey, Year)

ENRICO

29b. Signeture end title of certifie

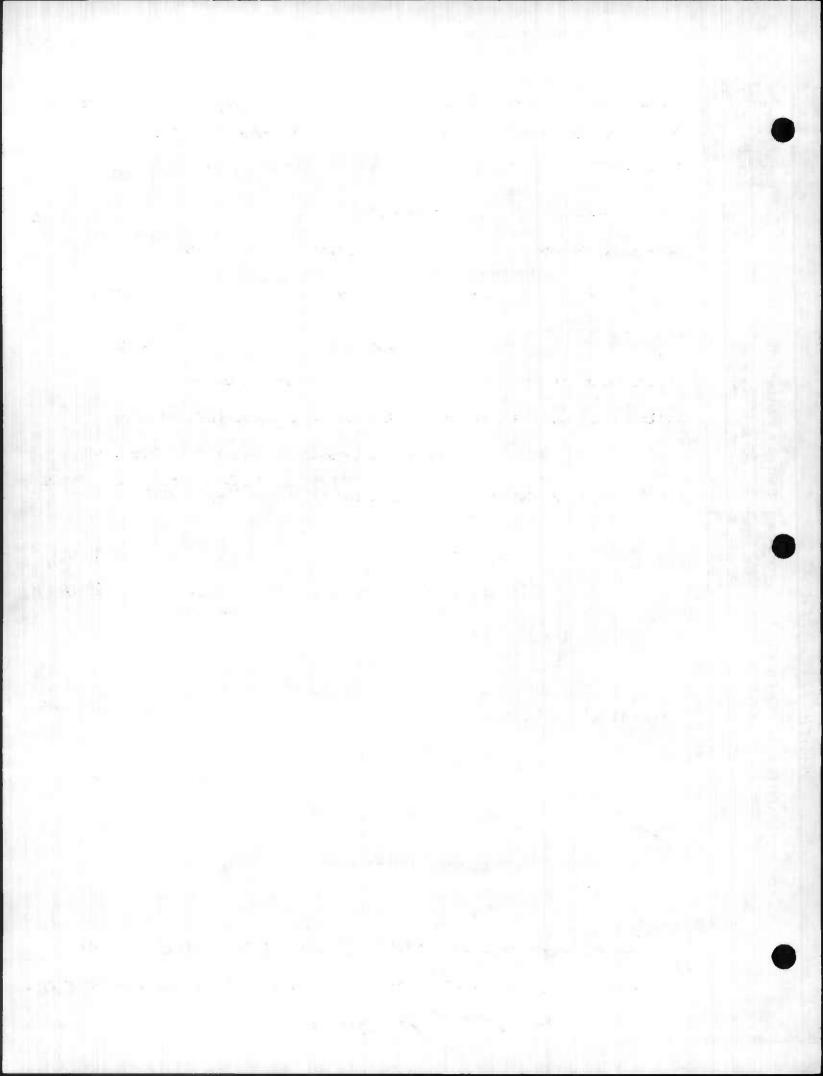
MAY 17 1999

30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

A. GIANGERUSO, M.D.

29c. License number

SMITH ELIZABETH



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State	of Maryland /	Department	of Health	and	Mental	Hygiene
		0	- 6 - 11	_		

Physician /Medical	TER		State of	of Ma	ryland / [		rtment tificate			d Me		jiene		7323		
	1	1. Decedent's Name (First, Middle GENEVIEVE Y		,	FER							2. Date of Dea Month MAY 1	th Day 1999	Year	3. Time of Deat	
Examine		4a Facility Name (If not institution MEMORIAL HOSPI			um <i>ber)</i>				1	tb. City, Town, CUMBER		ation of Death	4c. County ALLE			
Funeral Director		5. Social Security Number 563-26-6444	6. Se	ж Эм 2 <b>%</b> 0 F	7. Age	(In yrs. last bir	Yrs.	If Under 1 Months	Year Days	If Under 24 I Hours A	Ain.	8. Date of Birth (Month, Day SEPT 1	Year) 0,1911		place (Stete or For ntry) RYLAND	Bign
Maryland H ahow		Usual Residence of Decedent 10a. State 10b. County  MARYLAND AL	LEC	ANY		10c. City, Town							7.6		10d. Inside City Lin	
th with the Ma 23a or 28a-f		10e. Street and Number GENERAL DELI	VEF	RY				10f. Zip C	530	)		1	0g. Citizen of W	/hat Cou	ntry?	
020 020	של עמ	11. Marital Status  1 Never Married 2 Marr  3 XWidowed 4 Divorced	ied	12. Was Dec Armed For 1 Tayes If Yes, Gi Year or D	orces? 2 N ive	DDTAD		/as Decede Yes, specif		ispanic Origin'i nn, Mexican, Pi Specify:	(Specuerto R	city Yes or No- lican, etc.)	s or No- lac.) 14. Race - American Ind Black, White, etc. Specify: WHITE			
3	t end 2 should be flied within Haginah and Mental Hygiela within and Mental Hygiela with other traumatic event, the traumatic event, the traumatic event, the traumatic event, the traumatic event, the traumatic event, the traumatic event, the traumatic event, the traumatic event, the traumatic event, the traumatic event, the traumatic event, the traumatic event, the traumatic event, the traumatic event, the traumatic event, the traumatic event eve	15. Deceden (Specify only highe: Elementary/Secondary (0-12) 1 2			) (1-4or 5-	16a.	(Give k	ent's Usual cind of work O NOT use ORNE	done	during most of	workin	g	16b. Kind of Bu	siness/Ir	dustry	
Maryland d2 should be file th and Mental Hy 7 ie merked othe traumatic event,		17. Father's Name (First, Middle, HARRY YONKER	Last)							18. Mother's GRACE			Maiden Surnam	ө)		
ond 2 sho eath and n 27 is mer traums		19a. Informant's Name/Reletions ADAIR SCHAFF								ATHEN						
Pege ento	1	20a. Method of Disposition  1 SS Burial 2 Cremation  4 Donation 5 Other (S)			State	ST. J	y, crem	atory or oth	er plac			IAY	LOCKB		own, State	
Baltin permit. P Departm importer eny inju		21. Sygnature of Funeral Service	Licens	. H.	b		H	AFER	FU	SS OF FacilitY NERAL IONAL			ALE, MD	21	502	
Physician /Medical Examiner		23a. Part1. Enter the disasse, or shock, or heart failure. List Immediate Cause (Finel disease or condition resulting in deeth)	comp only o	lications that ne ceuse on	Mu	the death. Do re.  Liple Due to for as a	7	njuri		g, such as can	diac or	respiratory arr	est.	-	Approximate Intervel Between Onset and Death	
8760, sate be executed thysicien end the burlet-transit	a Evalli	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	5	b	ı	Due to (or as a o	consequ	ience of):						1		
0 5 5 5	3	that initiated events resulting in death) Last		d		oue to (or as a c	onsequ	ence of):		d <sub>e</sub> ,				1	4-55	
P.O. Be that the death and by the atte detached for Dhyseleja	aw requires that the death certiles been signed by the attending 2 should be detached for use pletted by Physician/M	Part It. Other significant condition	MS CO	ntributing to d	ibuting to death but not resulting in the underlying cause given in Pert I.							obecco use cor 'es 2 No	atribute i	to the cause of de		
Records, he law requires to has been signe age 2 should be completed by												24a. Was a perfor		81	Vere autopsy findin vailable prior to ompletion of cause I death?	
= F # & C		25. Was case referred to medical									D	1月4		ν	ÉYes 2□ No	
		examiner? 1 KXes 2 □ No	-	Hospital:	Inpatier	nt XXERVOu	tnations	3 DOA	Oth	er		(Check only or	ence 6 Oth	or /Snan	i6a)	
Attending Physics of the Innersid by the Innersid Michael Control of the Innersid Michael Cont	1	27. Manner of Death  1 Natural 5 Pendin 2 Accident investig	ation	28a. Date (Mor	-	Year) 28b. 1	ime of njury		c. Injur Wor		1	8d. Describe h	ow injury occurr	ed	acciden	+
D 9492		3 Suicide 6 Could determ		28e. Place	e of Inju	ry - At home, fa (Specify)		et, lectory. Leet				8f. Location (S City or Tow	treet and Numb n, State) This	er or Rui	ral Route Number,	
Hospital 24 hours Funeral etch filled	3				pasis of	examination an						and due to the cause(s) end manner es stated. red at the time, date end place, and due to the cause(s)				

21

State

Registrar

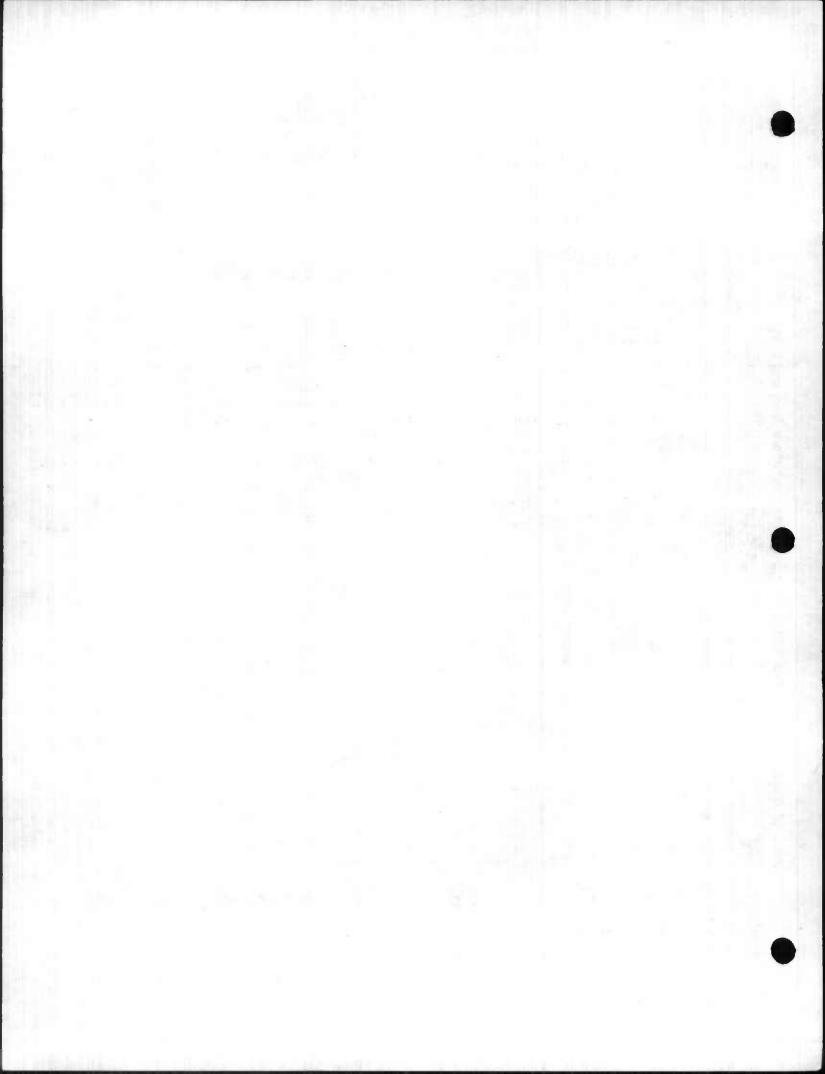
Dennis J. (31. Date filed (Month, Day, Year)
MAY 13 1999

29b. Signature and title of certifier

pleted cause of death (Hem 23a) (Type, Print)

11 Penn Street, Baltimore, Maryland 21201 3. Registrar's Signature

29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) MAY 12, 1999



					Cen	tificate	OIL	Jeath	1		Reg. No.		
n al	1. Decedant's Nama (First, Middle, Last) FRANK SOCHA									2. Data of D Month MAY 1	Dey	Yaar	3. Tima of Death 1:20 AM
	4a Facility Nama (If not institution,	giva straet end	number)		-		4	b. City, T	own, or L	ocation of Dea		ty of Death	
	MEMORIAL HOSE	PITAL						CUMBE	RLAN	D	ALLEG	TANY	
	5. Social Security Number	6. Sax 1⊡∕M 2□ F	7. Aga (In )			If Undar Months		If Unda Hours	r 24 Hrs. Min.	8. Data of B (Month, D	irth	9. Birth	hplaca (Stata or Foreign untry)
Ľ	143-18-5117		82		Yrs.						13 1917	NEV	W_JERSEY
ŀ	Usual Rasidanca of Dacedant  10a. Stata 10b. County 10c. City				, Town or Location								10d. Insida City Limits
	NEW JERSEY UNION EI				IZABETH								Yas 2□No
	10e. Street and Number				10f. Zip Coda						10g. Citizen of What Country?		
	207 MARSHALL STREET 07206								U.S.A.				
1	11. Marital Status 12. Was Decedant Ever in U. Armed Forcas?				S. 13. Was Decedant of Hispa If Yas, specify Cuban, I				ispanic Origin? (Specify Yas or Non, Maxican, Puarto Rican, atc.)		o- 14-Race - American Indian Black, Whita, atc.		
	1 Navar Marriad 2 Marri		s 2 No		1 ☐ Yas 2 ☑ No Specify:							Specify: WHITE	
3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: WW 1 1													
	15. Decedent's Education (Specify only highest grade completed)				Sa. Decadant's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired)					ing	16b. Kind of Businass/Industry		
	Elemantary/Secondary (0-12) Collega (1-4or 5+)				MECHANIC					MECHANIC			C
17. Fathar's Nama (First, Middle, Last)								ar's Nam	a (First, Middle		laiden Sumeme)		
	ANDRZEJ SOCHA				MARIAN					NA BIEL			
	19a. Informant's Nama/Relationsh	ip (Type, Print)		19b	o, Mailing	g Addrass	(Street	end Num	ber or Rui	el Route Num	ber, City or Tow	n, State, Z	Zip Code)
22. Nama and Addrass of Facility  MERRITT-ADAMS FUNERAL HOME  404 DECATUR STREET CUMBERLAND MARYLAND Approximeta shock, or heart failure. List doy one ceuse on each line.  Approximeta interval Between													
	23a. Part1. Entar tha disaasa, or shock, or haart failure. List	complications the	at caused tha d	aath. Doi	404	4 DEC	ADA	AMS I	FUNER	CHMBER	LAND MAI	RYLAN	Approximeta
	Immedieta Ceuse (Final disease or condition				404 not anta	4 DEC	CATUI	AMS I R STI	FUNER REET s cardiac	CUMBER or raspiratory	LAND MA	RYLAN	Approximeta Interval Between Onsat and Daeth
			TE ANTE		404 not anta	4 DEC	CATUI	AMS I R STI	FUNER REET s cardiac	CUMBER or raspiratory	LAND MA	RYLAN	Approximeta Interval Between Onsat and Daath
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3,12

(124)

31. Data filad (Month, Dey, Year) State Registrar





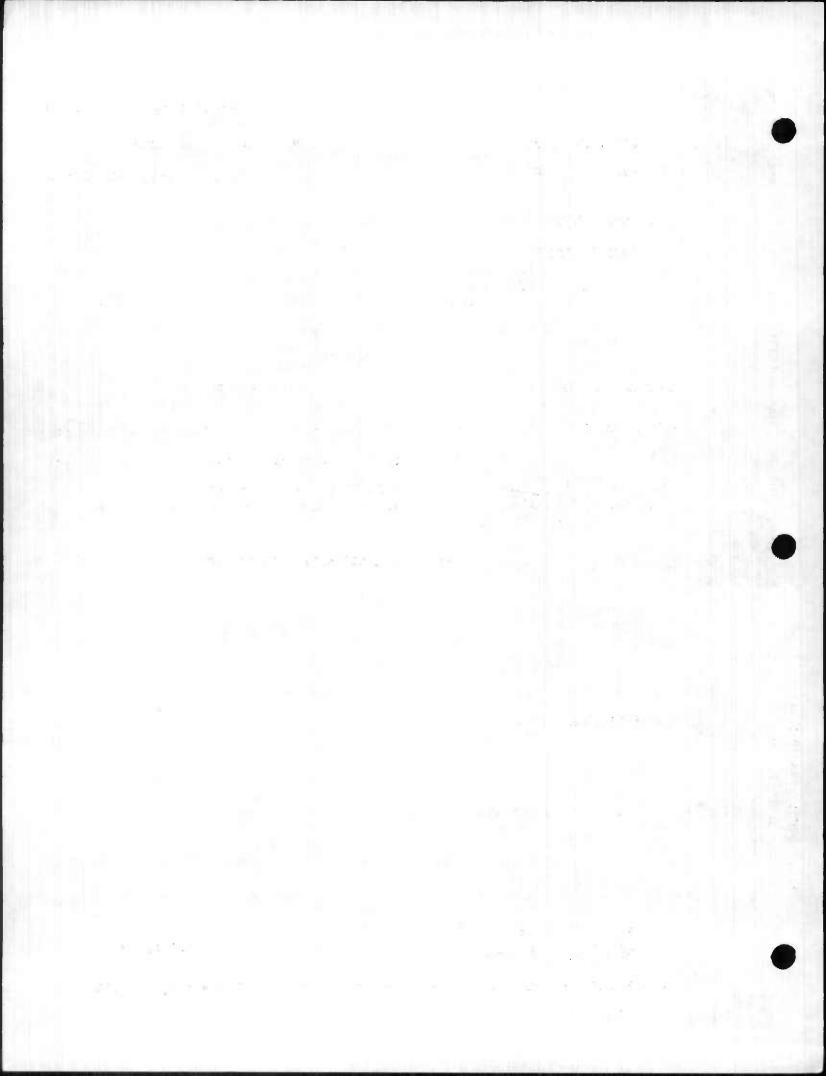
ROBUSTIANO BARRERA M.D., MEMORIAL MEDICAL BUILDING, CUMBERLAND, MD 21502

DHMH 16 Ray 6/95

Division of Vital Records, P.O. Box 68760,

FRANK SOCHA 143-18-5117

Baltimore, Maryland 21215-0020

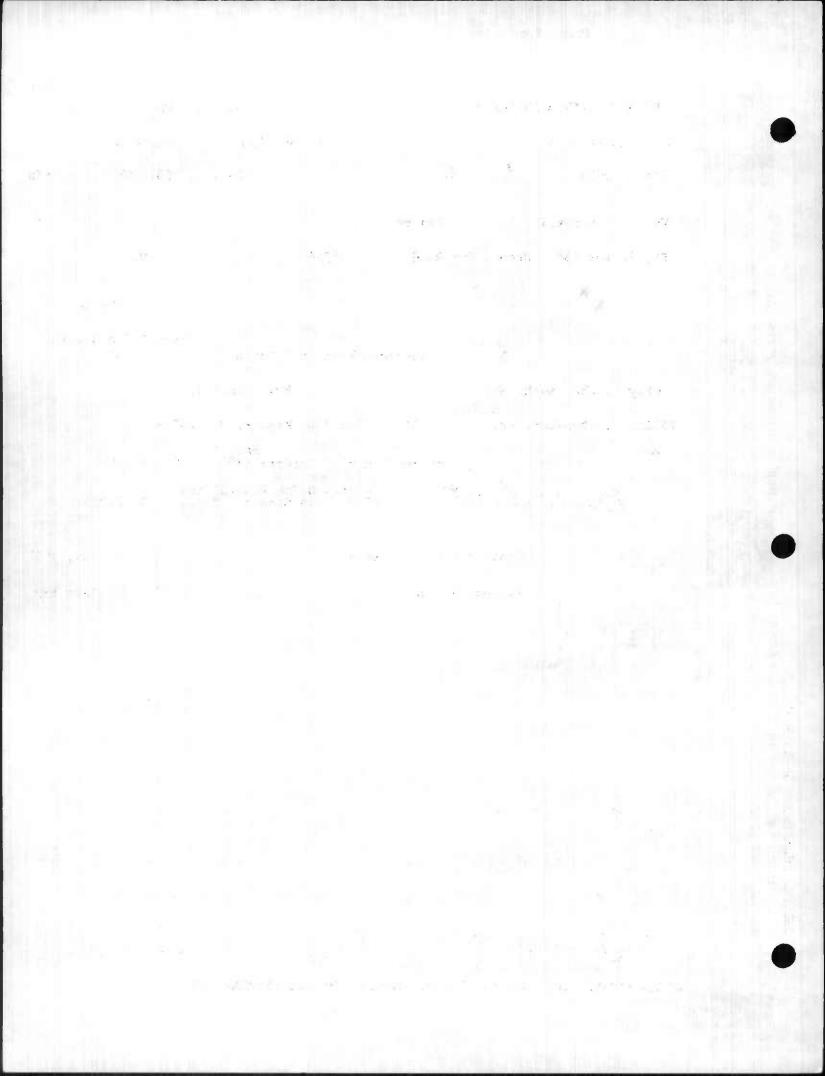


#### Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

	Olale (	or ivialylan		rtificate of	Health and M Death		Reg. No.		7325.
1. Decedent's Name (First, Mid		ED				2. Date of De Month	Day	Year	3. Time of Death
al DELUKES IK	ENE SHUMAK				4b. City, Town, or L	May 9,		of Death	04:45
MEMORIAL HOSP		31110017			CUMBERLAN		ALLEGA		
5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da	th	9. Birthi	plece (State or Foreig
234-46-3633	1□ M 20 <b>X</b> F	67	Yrs.	Months Deys	Hours Min.	Dec. 3			Virginia
Usual Residence of Decedent  10e. Stete 10b. Coun	nv .	10c. Cit	y, Town or Lo	ocation					10d. inside City Limits
	eral		eyser						1 ☐ Yes 2 No
WV Mine 10e. Street and Number	ELGI	K	eyser	10f. Zip Code			10g. Chizen of V	Vhat Cou	ntry?
Rt. 4, Box 2.  11. Marital Status  1 Never Married 2	38 Stone	y Run R	oad	2672	26		US	SA.	
11. Mantai Status		cedent Ever in U		Wes Decedent of H	Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No	- 14. Rac	e - Ameri	cen Indian,
1 Never Married 2 Married 3 Widowed 4 Divorce	rried 1 Yes	2 X No		1 ☐ Yes 2 😿 No	Specify:	7 110011; 010.)	Specify		olo.
3 ☐ Widowed 4 ☐ Divorce	Yeer or I							Wh:	Lte
	ent's Educetion est grede completed	)	(Give	dent's Usuai Occup kind of work done DO NOT use retire	during most of worl	king	16b. Kind of Bu		
Elementary/Secondary (0-12)	Coilege (	(1-4or 5+)			tical Nur	Se.	nospita	Home	Nursing
17. Fether's Name (First, Middle			Bicci	Ded Trac	18. Mother's Nam		, Meiden Suman		
Okey E. Che	noweth, Sr				Eva	Canfiel	d		
Okey E. Che	nship (Type, Print)	lusband	19b. Maili	ng Address (Street	and Number or Ru	ral Route Numb	er, City or Town,	State, Zi	o Code)
Willis R. Shu	maker, Sr.			4, Box 2	38 Keyse		26726		
20e. Method of Disposition  1   MBuriai 2 □ Cremation	3 □Removai from		Piace of Dispo cem <i>etery</i> , crei	osition (Name of matory or other pla	ce) M	ay 12	20c. Location -	City or T	own, State
4 Donation 5 Other	(Specify)	Po			Gardens	1999	Keyser	, WV	
21. Signature of Funeral Service	w.F.Su	itt	22		-Smith Fu ain Stree		ome ser, WV	267	26
23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that st only one cause on	caused the deat	h. Do not en						Approximate Interval Between
	, ,								Onset and Deeth
Immediate Cause (Final disease or condition resulting in deeth)	e. Acut	e Myelo	id Leu	kemia					Nov. 1997
		Due to (c	or as a conse	quence of):					
Sequentially list conditions,	b. Myel	lodyspla		45				-	July 1997
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	J	Due to (c	or as a consec	quence or):					
Cause (Disease or injury that initieted events	C	Due to (o	r as e consec	quence of):					
Cause (Disease or injury that initieled events resulting in death) Last  Part II. Other significant conditions	d								
Part II. Other significant condi	None contribution to	death but not ree	ulting In the U	Inderlying cause of	ven in Part I	23b Did	tohecco use co	ntribute	to the cause of death
Part II. Other significant condi	nons contributing to d	Jeath but not res	usting in the u	maenying cease gi	ven in ranti.		Yes 2 No		bably 4 Unknow
								,	
						24e. Was	en autopsy ormed?	a	vere autopsy findings vallable prior to
•								0	ompletion of cause f death?
						10	Yes 2 No	1	☐ Yes 2☐ No
25. Was case referred to medic examiner?		,			28. Place of Dea	ath (Check only	one)		
1 Yes 28 No	1		ER/Outpatie	IN SLI DOM		1	idence 6 Oth		ity)
27. Manner of Death 1. Netural 5 □ Penc	in A	of injury oth, Day Year)	28b. Time o injury	Wo	ork? ]Yes 2 □ No	280. Describe	how injury occur	red	
3 Suicide 6 □ Coul	d not be 28e. Piac	e of Injury - At h	ome farm st	reet, factory, office		28f. Location	(Street and Numi	ber or Ru	rel Route Number,
4 Homicide dete	mined 288. Plac	ding, etc. (Specif	(y)	root, ractory, emoc			wn, Stete)		
29a. Certifier 1 Certify	ring Physician: To the	e best of my kno basis of examina nner stated.	owledge, deet	h occurred at the ti vestigation, in my	ime, date and piece opinion, death occu	, and due to the rred et the time	ceuse(s) and m date and place,	anner as and due	stated. to the cause(s)
29b. Signature and the of certif		Tirior stated.		29c. Licen	se number		29d. Date signe	d (Month	, Day, Year)
1	Jan	ov,		D00	271		Moss 10	. 19	0.0
30. Name end address of person	n who completed ceu	use of death (Iten	n 23a) (Type.	D23	2/1		May 13	, 19	
OAMAR ZAMAN, M					DG.CUMBER	RLAND MI	21502		
e 31. Date filed (Month, Day, Yea	29	Registrar's Signs		1	3				
F BRAV 1 2	999	-	XJ.	all of the same	0				

DHMH 16 Rev 6/95

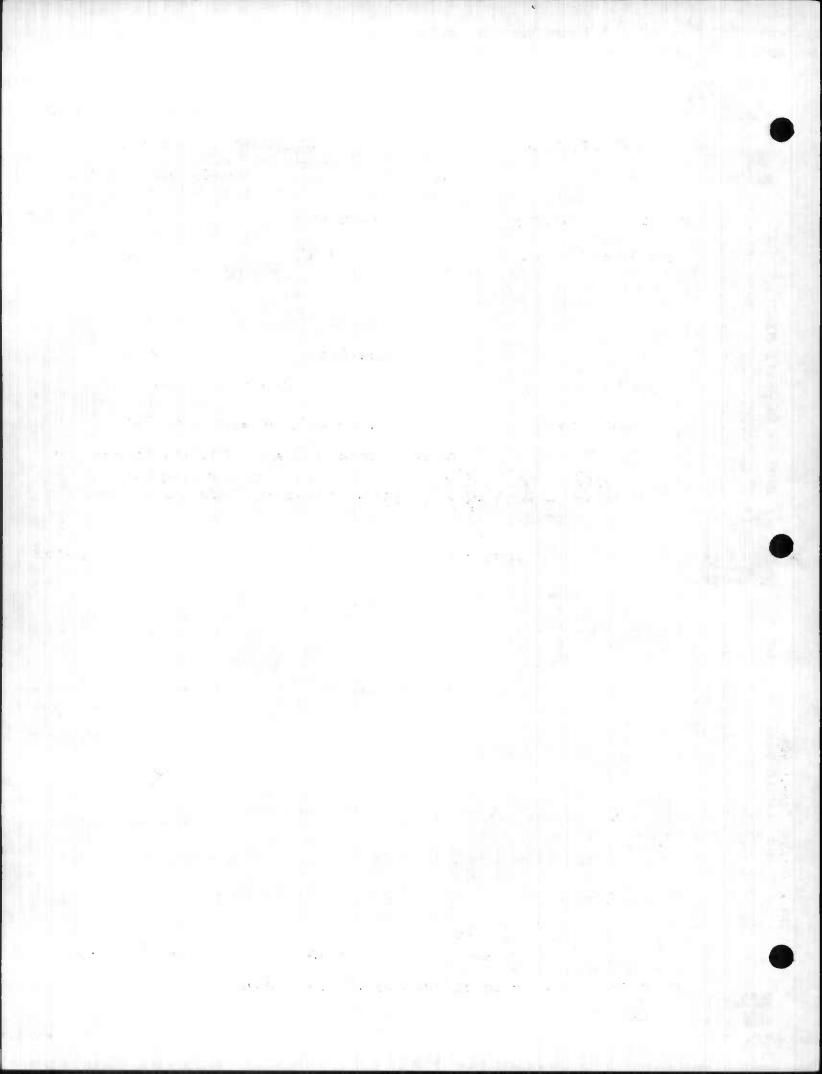
DELORES SHUMAKER



Amended #8, 5/19/99, Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

JRW, Allegany County State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Dey Month **Physician** 4b. City, Town, or Location of Death 1999 15:25 Sylvia M. Shears /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner CUMBERLAND
If Under 24 Hrs. 8 ALLEGANY MEMORIAL HOSPITAL If Under 1 Vac 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Hours 1 ☐ M 2 💢 F Yrs. 4ar. 3, 1923 Director 215-16-4897 Maryland 1923 Usual Residence of Decedent Mar. the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1√2 Yes 2 No Allegany Cumberland Directo Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with r than "natural", or itams 23s or the Medical Examiner must be USA 220 Somerville Ave. 21502 a death Funera Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status filed within 72 hours after Hygiene. 1 ☐ Yes 2 X No If Yes, Give 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorcad Year or Dates: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home other 7 is marked other traumatic evant, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) . Peges 1 and 2 should be file ment of Heelth end Mental Hi lant: if Nem 27 is marked oth jury or other traumatic evan Be Olive F. (Findlay) Cecil W. McKenzie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) P. O. Box 1317, Cumberland, MD 21502 Taylor C. Shears altimore, 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burlel 2 Cremetion 3 Removal from State permit. Pege Department of Important: If eny Injury or once. Rocky Gap Veterans Cemetery 5/17/99 Flintstone, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility Kight Funeral Home 21. Signeture of Funeral Ferrice Licensee 309-311 Decatur St., Cumberland, MD 21502 23a. Pent1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on early line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final 2 WEEKS PNEUMONIA disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner physician and the burial-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760, Physician/Medical Due to (or es e consequenca of): 60 080 ò P.O. signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 Unknown The law requires that Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed is certificate has be director, page 2 s 2 N No 1 🗆 Yes 1 □ Yes 2 □ No Physicien: Be 25. Was case referred to medical examiner?
1 \( \text{Yes} \) Yes 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To of this funeral 27. Manner of Deeth 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) After Division or Attending 5 Pending 1 Yes 2 No death. 2 Accident investigation Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury At home, farm, street, factory, offica building, etc. (5perify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hin 24 hours efter the Funeral Dire npletely filled in b Certifying Physician: To the best of my inowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier edical mination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) To the Complet 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signeture and title of certifier 3 16, 1999 D36766 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tus 21502 920 National Highway LaVale MD VIK POONAL, M.D., 32. Registrar's Signatur 31. Date filed (Month, Day, Year) State MAY 1 Registrar **DHMH 16 Rev 6/95** 



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Year **Physician** 0:800 APRO LeRoy Stansbury, Jr. February 26,1999
Pation of Death 4c. County of Death /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner 11718 Balsamwood Terrace Laurel Prince George's If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) If Under 1 Yeer Months Days 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** Days . Hours 10 M 2 F 220-22-4911 Director 67 June 11,1931 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d Inside City Limits than "natural", or herns 23a or 28a-f shor the Medical Examiner must be notified at 1 Yes Z No Maryland Prince George's Laure1 Directo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 11718 Balsamwood Terrace 20708 United States Funeral Wes Decedent of Hispanic Origin? (Specify Yea or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever In U,S. Armed Forces? 14. Race - American Indien, Black White etc. 1 XYes 2 No 1 Never Merried 2 Nerried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Black pernit. Pages 1 and 2 should be filed within 72 hours I Department of Health and Mental Hygiere. Important: If from 27 is marked offers than "netural", of any Injury or other traumatic event the Mantons Received 20 3 Widowed 4 Divorced Yeer or Detes: 9/52-9/54 Completed 15. Decedent'a Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 4 Mathematician Government 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be 2 LeRoy Stansbury, Sr. Ruth Williams 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois Stansbury / wife 11718 Balsamwood Terrace, Laurel, Maryland 20708 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Union United Meth, Church 3/3/99 Aberdeen, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Neme end Address of Facility 21. Signeture of Funerel Service Licensee Beard Funeral Home disa Scott 552 Lewis Street, Havre de Grace, Maryland 21078 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final YEARS CARCINOMA disease or condition resulting in deeth) Examiner physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760 Physician/Medical Due to (or es e consequence of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings aveileble prior to 24a. Wes an eutopsy performed? Completed completion of cause of death? 1 Yes 2 No 1 Yes 20 No 25. Wes case referred to medical axaminer? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death Ne Hospital or Attanding Ph n 24 hours after death. Ne Funeral Director: After th 28a. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: Division 1 Neturel 5 Pending investigation 1 Tyes 2 No 2 Accident Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, streef, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner as stated.

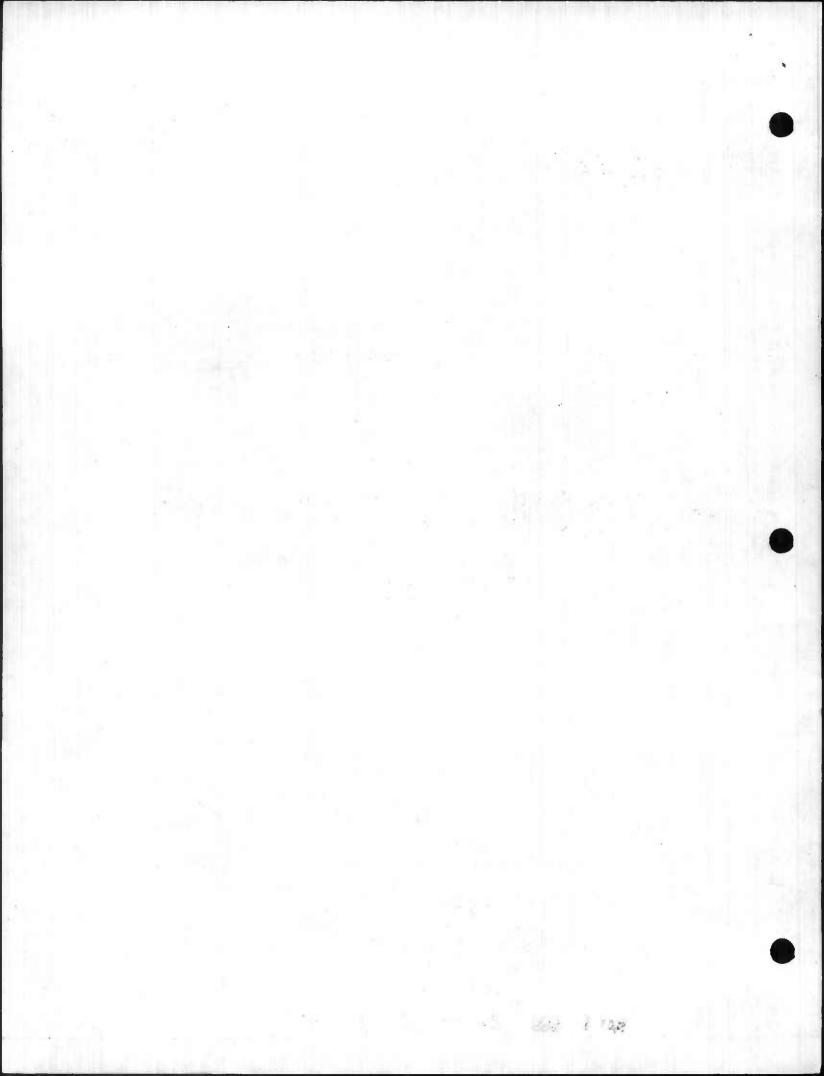
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. 29e. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) D50678 MIT 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) LOCKWOOD DE SILVESPRING, MD 20901 10801

Registrar **DHMH 16 Rev 6/95** 

State

31. Dete filed (Month, Day, Year)

32. Registrer'a Signature



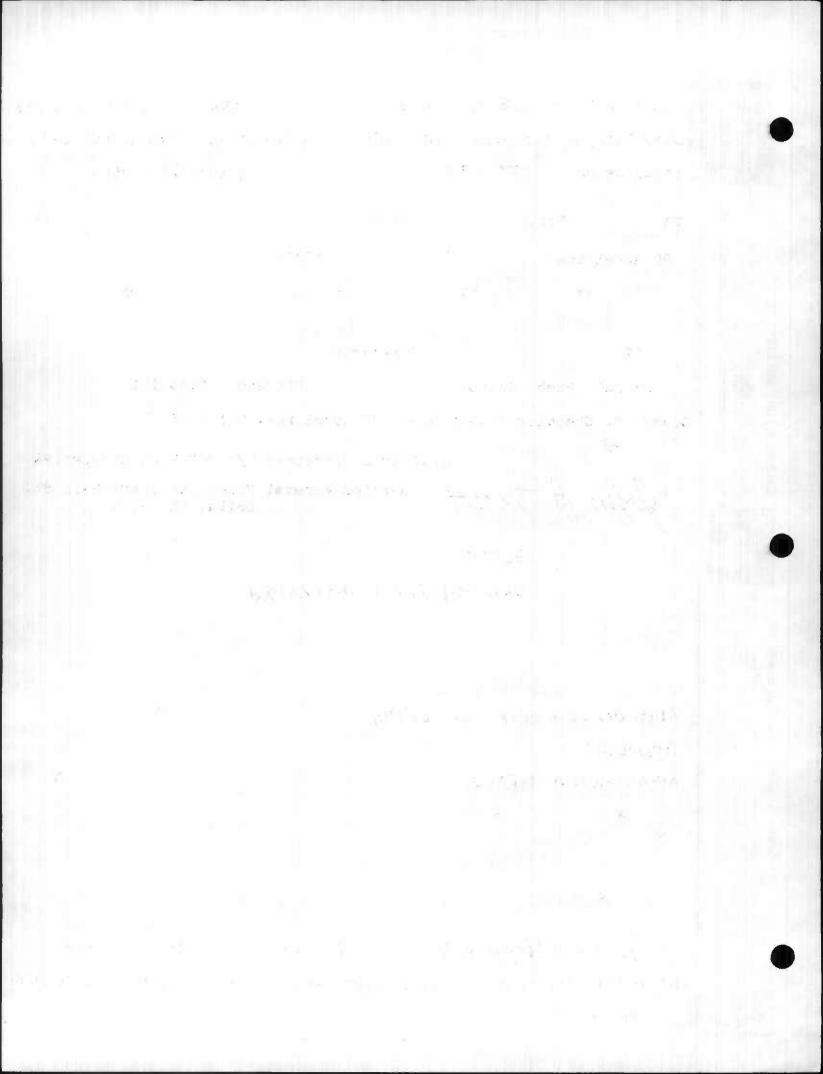
#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Daath 3. Time of Death 1. Decedent's Nama (First, Middla, Last) Month **Physician** BELLE STOCKLEY CLARICE 1999 Ma 11:10 AM 10 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva streat and number) 4c. County of Death **Examiner** BALTIMORE UNIVERSITY OF MARYLAND HOSPITAL BALTIMORE CITY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex Birthplace (Steta or Foraign Country) **Funeral** Days Months 10M 20X 78 6/19/1920 Utah Director 566-20-5930 Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or itema 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes ★₩No Director PA York Delta 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? USA 17314 Funeral 90 Aubel Road filed within 72 hours efter death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes ≥ ☐ No. If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Ricen, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 SpeciWhite 1 Yes XXNo Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) Homemaker 12 . Pages 1 and 2 should be filed w treent of Health and Mental Hygier tant: If Nem 27 Is marked other th jury or other traumatic event, the other 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middla, Maiden Sumeme) Be Gledhill Samue1 Rush Jacoby Florence 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 90 Aubel Rd., Delta, PA 17314 Edward D. Stockley Sr.-husband 20b. Pleca of Disposition (Nema of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - Cify or Town, State 1 ☐ Burial X Cramation 3 ☐ Removal from Stata Department of Important: If any Injury or once. R.A.Ferris Crematory 5/11/99 West Chester, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harkins Funeral Home, Inc., 600 Main St. At 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximata Interval Between Onsat and Death **Physician** /Medical Immediate Cause (Final SEPSIS diseasa or condition resulting in death) Examiner Due to (or es a consequenca of): Examiner INFECTION URINARY TRACT sician and buriel-transit death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequenca of): physician the buriel Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) 98 use signed by the a d be deteched f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown ADENOCARCINOMA OF LUNG 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy Completed THYMOMA page 2 1 Tes 2MNo 1 ☐ Yes 2 No certificate MYASTHENIA GRAVIS Attending Physician: Be 25. Was case referred to medical examiner? 26. Placa of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Rasidanca 6 Other (Specify) 1□ Yes 2No Certification: To this funeral 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Neturel 5 Pending after death. Director: Aft 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 24 hours after Funeral Oire letely filled in b 6 29a. Cartifier KCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner es steted. Medical 2 Medical Examinar: On the basis of examination and/or Investigation, In my opinion, death occurred at the time, date and placa, and due to the cause(s) and mannar stated. (Check only one) To the I within 2 To the I complet 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier in Hypp P11759 May 10, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22 South Greene Street Baltimore, Maryland 21201

State Registrar Jennifer Hoppind

31. Date filed (Month, Dey, Year) MAY 13 1999 32 Registrar's Signature



Registrar

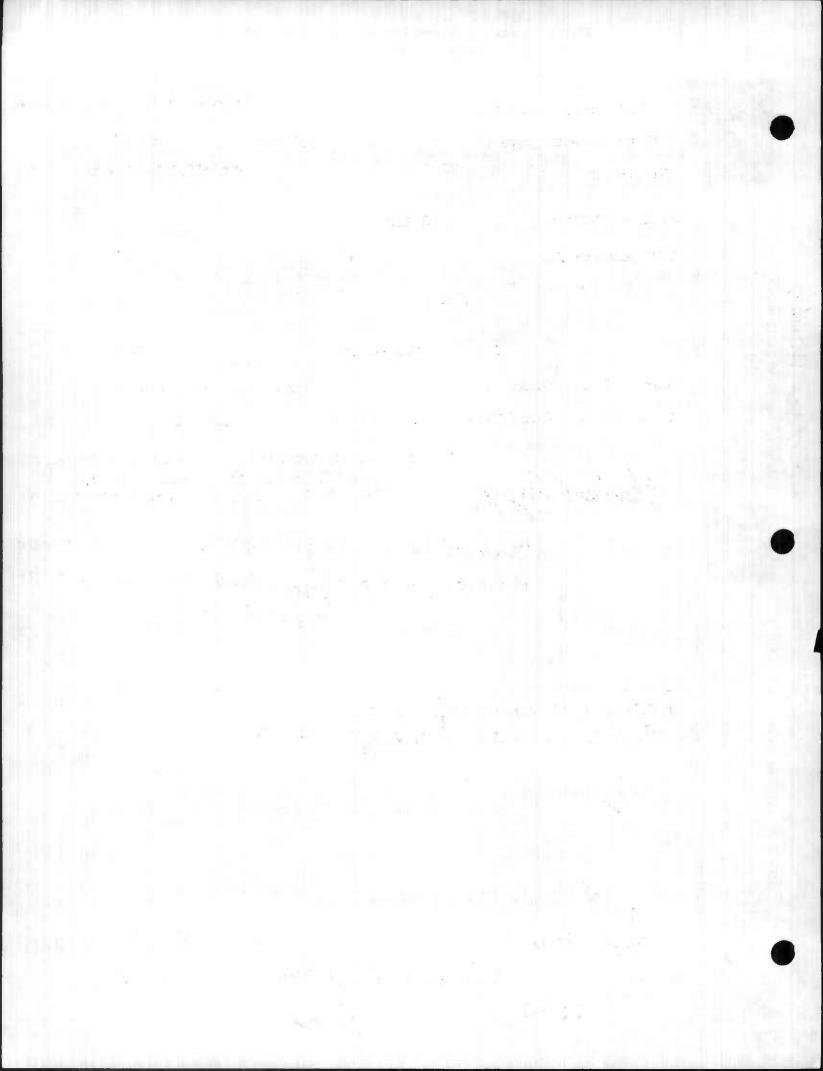
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name /First Middle | ast) 2. Date of Death 3. Time of Death Month **Physician** 9th 1999 1:58 AM HENRY (nmn) Solter, Jr. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Fallston General Hospital Fallston Harford If Under 1 Year 8. Date of Birth (Month, Dey, Year) Jan. 18,1916 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. Hours ₩ M 20 F Months Davs 83 Director New York 051-07-9802 10a State 10c. City, Town or Location 10b. County 10d. inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at the Maryle 1 Yes 2 No Maryland Directo Harford Bel Air 10e Street and Number 10f Zin Code 10g Citizen of What Country? 21015 Funeral 1002 Seamount Rd USA 12. Was Decedent Ever in U,S. Armed Forces?

1 XYes 2 No. If Yes, Give Race - American Indian, Bleck, White, etc. 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Maritel Stetus 1 Never Married 2 X Married 1 Yes 2 No Specify: p 3 Widowed 4 Divorced Yeer or Dates: WWII White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Brewery Brewmaster 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Depertment of Health and Mental Important: If Item 27 is marked o Henry (nmn) Solter, Sr. Elizabeth Wagner 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Boute Number, City or Town, Stete, Zip Code) Ann Elizabeth Solter/ Wife 1002 Seamount Rd. , Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 0 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Bel Air Memorial Gardens 5-12-99 Bel Air, Maryland 22. Name and Address of Facility HOWard K. McComas III Funeral Home, P.A. Funeral Service Licens 1317 Cokesbury Road, Abingdon, Maryland 21009 ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, 23a. Part1. Enter the disease, or complications, or heart failure. List only one Approximete Interval Between Onset end Deeth **Physician** Cerebral hemarhag /Medical Immediate Ceuse (Final 5-7.1999 disease or condition resulting in deeth) Examiner therapy for acute myo cardil Examiner toc man boly pue the bunal-tran Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last as a consequence of): physician that the death certificate be Physician/Medical Due to (or as a consequence of): 98 0 signed by the a Part.II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributa to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown al usar trow by 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of ceuse of death? Seu 1 ☐ Yes 2 ☑ No 1 Yes 2 No certificate funeral director, 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA this 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred or Attending Fafter death. After 1 Neturel 5 Pending investigation 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 | Homicide Hospital 24 hours a Funeral C 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier Medical (Check only one) To the I within 2 29d. Dete signed (Month, Day, Year) 29b. Signature end title of certifie 29c. License number Attending 30. Neme and address of person who completed cause of beeth (Item 23e) (Type, Print)
VIJAX.S. NAIR M.D. 2112 Belair Road. Fallston. MD 21047 32. Registrar's Signature 31. Date filed (Month, Day, Year) 1999 MAY 11 Deneva

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.



99-2850-510 99-106

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State of Maryland	/ Department	of Health	and Mental	Hygie
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nd / Department of Health and Me	ental Hygiene	170	21
Certificate of Death	Reg. No.		

	/Medic Examin Funeral Director	16
Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23s or 28s-f show any injury or other traumatic event, the Modes I Environment or notified at ODCs.	
	Physician /Medical	

EMILY I	Μ.	SIMON			Certificate of	f Death	F	leg. No.		1.000
		1. Decedent's Neme (First, Middle, La	st)				2. Dete of Dea Month	ith	Year	3. Time of Death
Physici /Medio		Emily Marie Si	mon				MAY	17, 19	999	8:33P.M.
Examir		4e Facility Neme (If not institution, give	re street end number)			4b. City, Town, or L	A STATE OF THE PARTY OF THE PAR	4c. County	of Deeth	
	_y	SHOCK TRAUMA CENT	ER			BALTIMOR	E			
Funeral		5. Social Security Number 6. S	Sex 7. Age	e (In yrs. lest bi	Months Day		8. Dete of Birth (Month, De)	Year)	9. Birth	place (State or Foreign
Director		Usuel Residence of Decedent	DM 2DL	29	Yrs.		Feb. 9	, 1970		yland
anylar	-	10a. Stete 10b. County		10c. City, Tow	m or Location					10d. Inside City Limits
the Marylar 28a-f show nouthed at	cto	Maryland Harfo	ord	Jopp						1 ☐ Yes 2 💢No
ctor death with the Maryla after death with the Maryla or items 23s or 28s-1 show	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of 1	What Cou	ntry?
23 a	Ta.	521 Joppa Farm F			Jop			USA		
er de	Funeral	11. Meritei Stetus	12. Was Decedent B Armed Forces?		If Yes, specify Cu	Hispanic Origin? (Sp Iban, Mexican, Puerto	Rican, etc.)	14. Hed Ble	e - Ameri k, White,	etc.
	by	1 Never Merried 20 Merried 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Yeer or Detes:	10	1□ Yes 2√2 N	o Specify:		Specif	Wh:	ite
n 72 hours at	Completed	15. Decedent's E (Specify only highest gro		168	Decedent's Usuel Occ (Give kind of work don life, DO NOT use reti	e during most of work	ing	16b. Kind of B	usiness/Ir	dustry
d within giene.	dmo	Elementery/Secondery (0-12)	College (1-4or 5					Reta	:1 174	- Face
7 6 9 8		17. Father's Name (First, Middle, Last		50	les Repres	18. Mother's Nem	e (First, Middle,			X
Z E P	o Be	Irvin Clem Stobie				10.0				
2 should and Men is marke	F	19a. Informent's Neme/Reletionship (		198	. Meiling Address (Stre		lizabeth		State Zi	n Code)
2 2 2 2	17	Gerard Stanislaus								
Health Health Them 27 other tr		20e. Method of Disposition	DIAMITOIT.	20b. Plece C	Disposition (Neme of	yrd Street	Defe	20c. Location	City or T	own, Stete
Page mt: if		1 DBurial 2 □ Cremetion 3 □ 4 □ Donetion 5 □ Other (Special	(y)		ry, cremetory or other peorges Episc	copal Cem.	-21-99		-	Maryland
permit. Departri Importa any Inju		21. Signature of Fungral Service Lice	~ · /		Howard K	ress of Facility McComas esbury Roa	III Fund	eral Hor	ne, I	P.A.
		23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that caused	the deeth. Do					гутац	Approximete
Physician		SHOCK, OF HEER FAILURE. LIST UTILY	Card Gallagon Bach III	#					1	Onset end Deeth
/Medical		Immediete Cause (Finel diseese or condition	N.	1+0	1				- 1	
Examiner		resulting in deeth)	a. / · (w	Due to (or es e	consequence of):				1	
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oute ransi	Examiner	Sequentially list conditions.	b. —	Due to (or es a	consequence of):					
ing and		Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury								
rificate be executed ng physician and as the buriet-transit	edical	that initiated events resulting in death) Last	c	Due to (or es e	consequence of):					
# 8 m	Ne de	resulting in death) Last							1	
death cer e attendin	Se		d						1	
. 0 0 0	Physician/M	Pert II. Other eignificant conditions of	ontributing to death bu	it not resulting i	n the underlying cause	given in Pert I.	23b. Did t	obacco use co	ntribute I	o the cause of death
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sician: The certificata lirector, pag	Be	25. Was case referred to medical				26. Place of Dee	th (Check only or	ne)		1
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To the Hospital or Attend within 24 hours after deati To the Funeral Director: completely filled in by the					, deeth occurred at the					
the P	Medical	one)	end manner ste	ted.						
5 vit	2	29b. Signature and title of certifier	11.		29c. Lice	nse number		29d. Dete signe	d (Month	Day, Year)
		Morha M	14the	vo	0.0	C.M.E.		MAY 18,	1999	
6		30. Neme and eddress of person who		eth (Item 23a)						
			KIT		111 Per	n Street,	Baltimo	ore, Mai	ylar	d 21201
Sta	te	31. Dete filed (Month, Day, Year) MAY 2 0 1999	Registre	r's Signeture	Sports					
Registra	ar	MAI w 0 1333	1	~	Jagorates					
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Alli			1. Decedent's Name (i	First, Middle, Las	t)	3-99	CI		-		2. Date of D			3. Time of Death
	Physici /Medi		DORIS CLA	ARISSA T	ABITHA TA	YLOR					Month	9,	1999	3:42pm
	Examir		4a. Facility Name (If no	ot institution, give	street end number	)			4	b. City, Town, or I		-	c. County of Death	J. 42 DIII
	Funeral Director		5. Social Security Num 214–37–3326	6. Se	unity Ho		last birthday	) If Under 1 \ Months D	Year Days	Lanham If Under 24 Hrs. Hours Min.		rth	9. Birthp	George's lace (State or Foreign ltry) Leone, W.A.
	pua *		Usual Rasidence of De 10a. Stete 16	ocedent 0b. County		10c. Cit	y. Town or L	ocation					1	0d. Inside City Limits
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	28a-f	Director	10e. Street end Numbe		eorge s	9	reemo	10f. Zip Co	nde		1	10a C	Itizen of Whet Cour	400
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200	ter death frems 2	Funerai	11. Marital Stetus	ige ruin	12. Wes Decedent	Ever in U	,S. 13.	Was Deceden	t of HI	Ispanic Origin? (Si	pecify Yes or N	-	14. Race - Americ	an Indien,
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Вох	atth certifications after use a	Physician/M			d							11	My Mil	Shy EXP
	the a	sic	Pert II. Other significan	nt conditiona co	ntributing to death b	out not resu	ulting in the u	underlying ceus	se give	en in Pert I.	23b. Did	tabeco	ontribute to	the cause of death?
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۵	urs al	Ce		1										
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate his completaly filled in by the funeral director, page	edical Certification:	29a, Certifier 1 (Check only one)	Certifying Phy Medical Exam	sician: To the best ner: On the besis o end manner st	f examinat	wledge, deat tion and/or Ir	th occurred at the evestigation, in	ha tim my op	e, date and place, pinion, daath occur	, and due to the rred at the time,	cause(s data en	s) and manner as si od place, and due to	ated. the ceuse(s)
	To the To the Comp	Me	29b. Signeture end title	of certifiar				29c. LI	lcense	number		29d. Da	ate signed (Month,	Day, Year)
				7	rull II			DL	12	684		MAU	9 194	9
	(4)		30. Nama and addrass	of person who o	omplated cause of c	leath (Item	1 23a) (Type	, Print)	4	001		- 7	1	
<u> </u>	U		Jay	ZWALL	y II	Doc	tors	Comm	nu	nity 1	ospit	= (		
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State of Maryland / Department of Health and Mental Hygiene

ANGELUS TSIOLIS Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3 Time of Death Day 1999 Month MAY Physician 8, 0750 AM Angelos Tsiolis /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MUNCASTER & BOWIE MILL ROAD MUNCASTER MONTGOMERY H Under 1 Year M Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Yrs. 18 Director 213-19-9838 Virginia Dec 30,1980 Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Ves 2□No Director Md Montgomery Derwood 288-1 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8 6736 Heatherford Court 20855-1521 "netural", or Items 23a USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Bleck, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: Never Merried 2 Married Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if hen 27 is marked other than "n any Injury or other traumetic event Elementary/Secondary (0-12) College (1-4or 5+) School School 11 Student 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Stavros Tsilios Sophia Kambanidou 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sophia Tsiolis/ Mother 6736 Heatherford Ct. Derwood, Md. 20855
ace of Disposition (Name of Dete 20c. Location - City or Town, State Baitimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State Gate of Heaven 5/12/99 Silver Spring, Md. 4 □ Donetion 5 □ Other (Specify) 21. Signature of Euneral Service Licenses 22. Name and Address of Facility Killer PHILIP D RINALDI FUNERAL SERVICE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Silver Spooking at Md. shock, or heart feiture. List only one cause on each line. Interval Between Onset and Deeth **Physician** Immediete Cause (Finel disease or condition resulting in death) /Medical INJURIPS Examiner Due to (or as a consequence of): Physician/Medical Examiner physician and the burial-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Box 68760, that initieted events resulting in death) Last Due to (or as a consequence of): 980 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records. à The law requires should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? Completed page 2 s has 12 Yes 2 □ No 1 Yes 2□ No certificate of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 XX ther (Specify) AT SCENE XXYes 2 No Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Division Attending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fund 1 Natural 5 Pending investigation 1 Yes 2. No --8-99 0745 2 Accident Motor vehicle accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Muncaster Mill 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide STARET

Montgomery County, Mary land

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

XIX Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E MAY 9, 1999

State Registrar

**DHMH 16 Rev 6/95** 

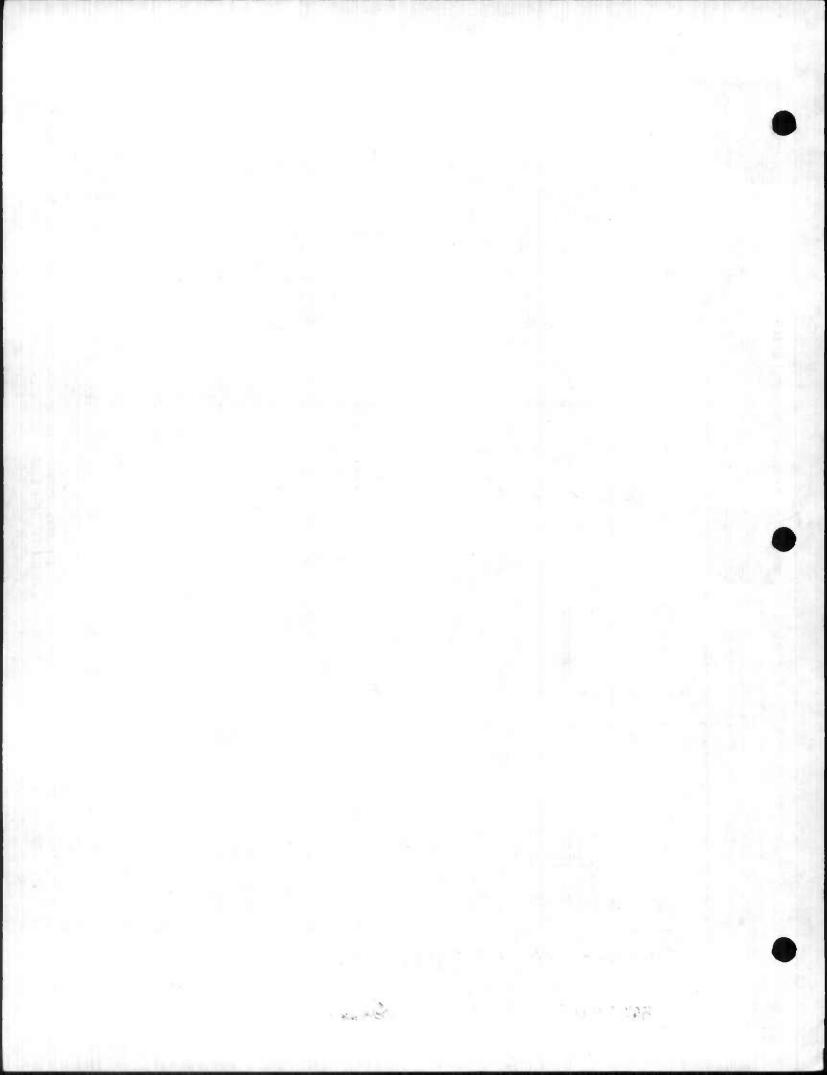
30. Neme and address of person who completed cause of death (Item 288) (Type, Print)

Strphyn S. 1 31. Date filed (Month, Day, Year) MAY 1 0 1999

5,

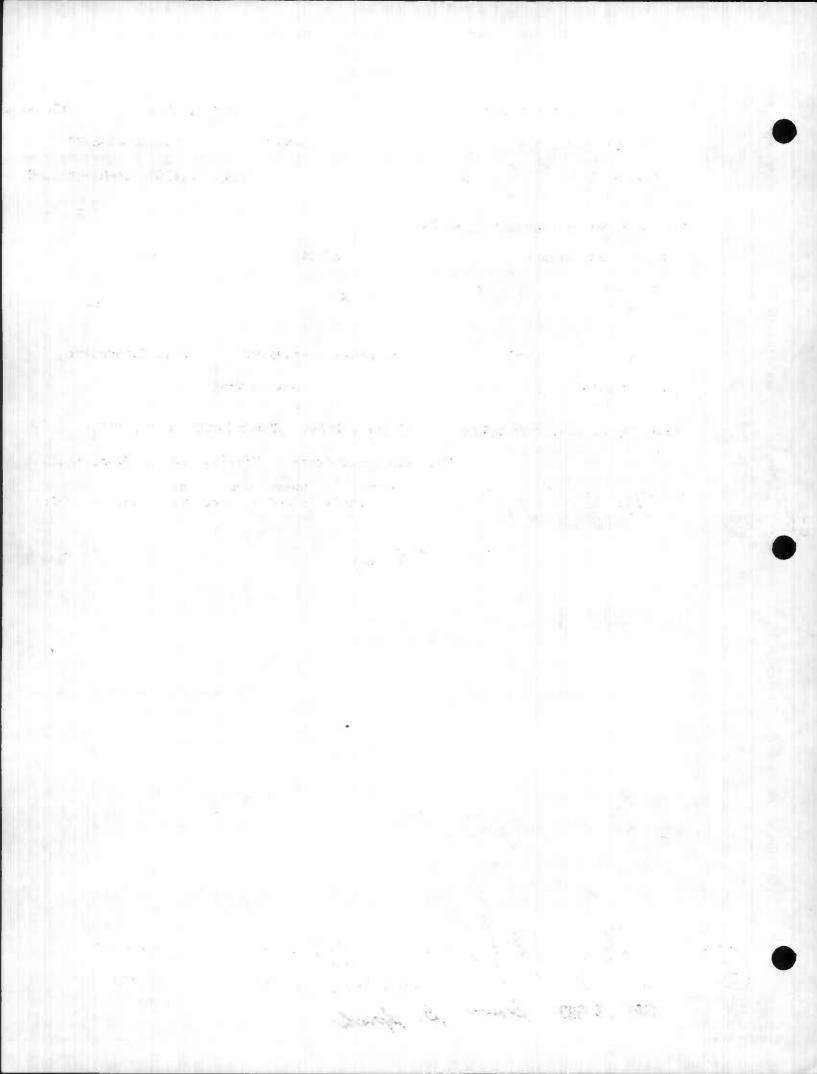
Radentz 111 Penn Street, Baltimore, Maryland 21201

2. Registrar's Signature



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	1. Dece	edant's Name (First,	Middle, Las	st)		JIP				2	Data of Dea Month	th Day	Year	3. Tima of Death
ician dical		MARVA	MARSE	HALL TA	YLOR						MAY 7,		1001	1:30 A.M
iner	4a Faci	lity Name (If not ins	titution, give	a straet and n	number)	4b. City,			4b. City, Town,	or Loca	tion of Death	4c. Cour	nty of Death	h
	-	9302 CALANDA STREET				LANHA					PRINCE GEORGES'			
	5. Socia	al Security Number	6. S	ex □M 2 <b>X</b> 0 F	7. Age (In		Yrs. Mont	hs Days	If Under 24	fin.	Date of Birtl (Month, Day			hplace (State or Foraign untry)
		3-54-5561 Residence of Decede			58		113.			A	ug. 16	,1940	Wasi	hington,DC
	10a. St				100	c. City, To	wn or Location							10d. inside City Limits
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Directo	10e. St	reet and Number	ICE_O	corgea				Zip Code				10g. Citizen o	of What Cou	untry?
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-	19a. In	formant's Name/Rei	ationship (7	Type, Print)		15	9b. Mailing Add	rass (Street	and Number o	Rural F	Route Numbe	r, City or Tow	vn, Stata, Z	Zip Coda)
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State of Maryland / Department of Health and Mental Hygiene

					Certifica	ate of	Death		Reg. No.		1111
Dhysisian	1. [	Decedent's Neme (First, Middle, La	st)					2. Dete of De Month	Day	Yeer	Time of Death
Physician /Medical		Nancy	Lorraine T	ates				May 8,	1999	3:	15P.M.
Examiner	4a	Facility Neme (If not institution, give						r Location of Dee		y of Death	
		Prince George'	s Hospital	Center			Cheve			e George	e's
Funeral Director		Social Security Number 6. S 579-64-8037 uel Residence of Decedent	Sex 7. Age	(In yrs. lest b	Yrs. If Unc Month	der 1 Year S Deys	If Under 24 H Hours Mi	n. May 25	irth Y 1950	9. Birthplace (Virginia)	Stete or Foreig
Habow Hedal	10a	a. Stete 10b. County	e George's	10c. City, To	wn or Location Lanham	1					side City Limit
inter deem win me ma river must be notified Funeral Director	10e	9204 Morley Ro	ad		10f. 2	Zip Code	2070	16	10g. Citizen of	What Country?	
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certificata rector, pag	25.	Was case referred to medical					26. Place of D	eath (Check only	one)		
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Physician /Medical Examiner

**Funeral** Director

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Baltimore, Maryland 21215-0020

Box 68760

P.O.

Records.

Division of Vital

permit. Pages 1 and 2 should be file.
Department of Hestilts and Mental Hy importants if them 27 is married other any Injury or other Physician /Medical Examiner

> physician and s the burial-transit that the death certificate be executed 2 attending | detached been signed by t should be detact page 2 certificate Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica etely filled in by the funeral director, I in 24 hour. edical To the Hosp within 24 ho To the Fune completely f

Directo 10e. Street and Number 2571 Funeral à Completed å Frank 2 Examiner Physician/Medical þ Completed Be XXYas 2 No Certification: To 27. Mannar of Death Netural 2 Accidant 3 ☐ Suicide 4 Homicide 29a. Cartifian

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Day Month Frank Thompson TTT MAY 07, 1999 6:40 PM. 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death 2571 KIRK AVE. BALTIMORE n/a If Under 24 Hrs. If Under 1 Yaar 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) 8. Data of Birth (Month, Day, Year) Months Deys Hours 110 M 2□ F 50 578-66-1418 October 20,1948 Maryland Usual Residance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Maryland Baltimore 10f. Zin Code 10g. Citizen of What Country? Kirk Avenue 21218 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 12. Wes Decedent Ever in U,S. Armed Forcas? 14. Race - Amarican Indian, Black, Whita, atc. 1 Nevar Merried Merried ☐ Yes 2 No f Yas, Giva 1 ☐ Yas 2 No Specify: Specify: **Black** 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highest grada complated) 18b. Kind of Business/Industry Pinkerton Security Elemantary/Secondery (0-12) Collega (1-4or 5+) Company Security Supervisor 3 years 17. Fsthar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Thompson, Jr. June Henson Butler 19a. Informant's Name/Ralationship (Type, Print) (wife) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 2571 Kirk Avenue, Baltimore, Maryland 21218 Sheila Laverne Berry Thompson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramovel from Stete May 13,1999 4 ☐ Donation 5 ☐ Other (Specify) National Harmony Memorial Park Landover, Maryland 22. Nama and Addrass of Facility Robert G. Mason Funeral Home, Inc. 21. Signatura of Funaral Sarvica Licenses 1661 Good Hope Road, S.E.; Washington, D.C. 20020 Mus 23a. Part1. Enter the disease or complications that causad tha daath. Do not anter tha mode of dying, such as cardiac or respiretory errest, shock, or haart failura. List only ona cause on each line. Approximete tntarval Between Onset and Deeth fmmediata Causa (Final disaase or condition resulting in daath) Arteriosclerotic Cardiovascular Disease Dua to (or as a consequence of): Sequentially list conditions, if any, laading to immadiate cause. Enfar Undarlying Cause (Disaasa or injury that initiated events rasulting in death) Lasl Dua to (or as e consequence of): Dua to (or as a consequence of). Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an eutopsy performed? INSPECTION 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No 26. Place of Death (Check only ona)

24b. Were eutopsy findings available prior to completion of cause of death? 25. Was casa rafarred to medical Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 🖾 Residence 8 Othar (Specify) 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 5 Pending invastigation 1 ☐ Yas 2 ☐ No 6 Could not be datarmined 29f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Ptaca of Injury - At home, ferm, street, factory, office building, atc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. (Check only one)

29b. Signatura and titla of certifiar

29c. License number

29d. Dete signed (Month, Day, Year)

O.C.M.E.

MAY 08, 1999

30. Nama and addrass of person who completed cause of deeth (frem 23a) (Type, Print)

Stephen Radentz, M.D.

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year) MAY 1 2 1999 State Registrar

32. Registrar's Signature

frank

the state of the

1981 . J. YAM

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

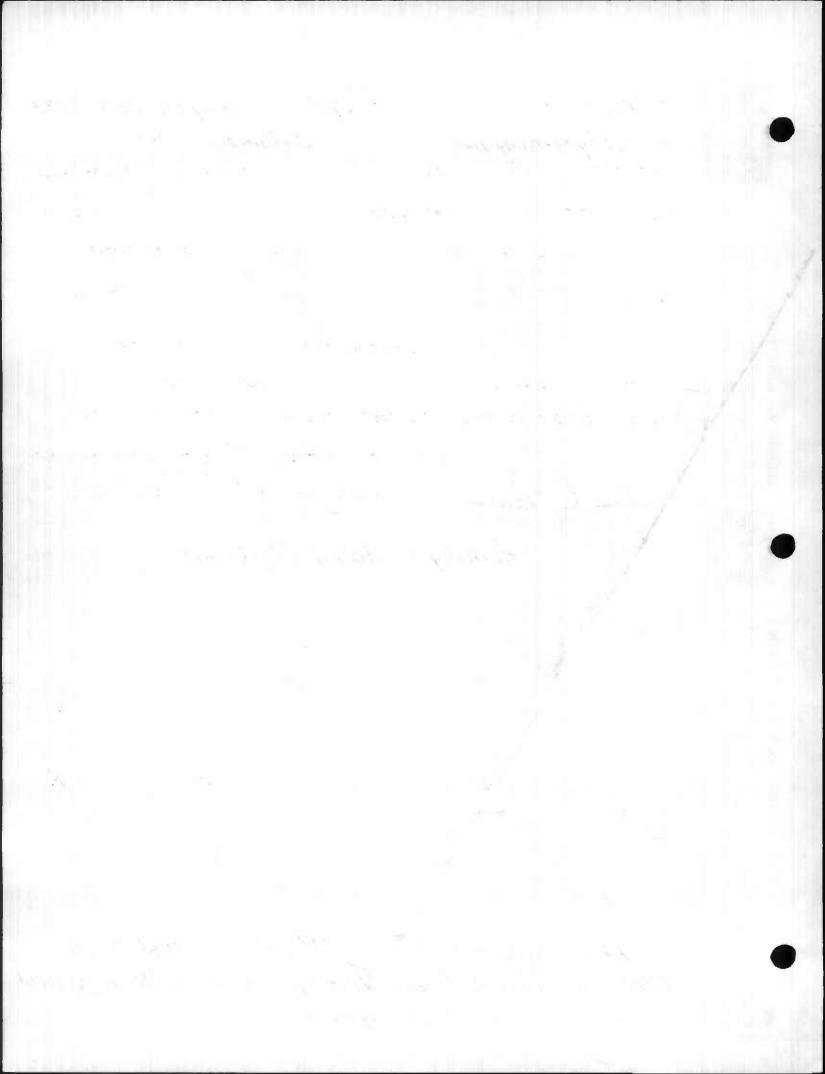
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** /Medical or Location of Death 4c. County of Death 4b. City, Town Examiner N/A MIMORE 8. Date of Birth (Month, Dey, Year) If Under 1 Months If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 10 M 20 F Davs Min. Hours 214-48-4779 43 PENNSYLVANIA **Director** Usual Residence of Decedenf the Meryland 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County "natural", or items 23s or 28s-f show adical Examiner must be notified at MARYLAND FREDERICK **EMMITSBURG** 1 Yes 2 No Director 10a. Street and Number 10f. Zlp Code 10g, Citizen of What Country? with 512 EAST MAIN STREET 21727 UNITED STATES Funeral Pages 1 and 2 should be filed within 72 hours efter death nent of Health end Mental Hyglene.
Int: If item 27 is marked other than "natural", or itema 23 mr. or dre traumatic event, in the death and a fracting must my or other traumatic event, in the death and a fracting must 12. Was Decedent Ever In U.S. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No
if Yes, Give
Year or Dates: Black, While, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 WHITE 1 Yes 2 No Specify: Specify: þ 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) EDUCATION DEAN'S ASSISTANT 12 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be NANCY R. GERKEN GEORGE L. DANNER, JR. 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a, Informant's Name/Relationship (Type, Print) EMMITSBURG, MD. 21727 ALISON A. TOPPER / DAUGHTER 512 EAST MAIN STREET MAY 20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Depertment of Important: If ony injury or NEW ST. JOSEPH'S CEMETERY 1999 EMMITSBURG, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) 22. Neme and Address of Facility 21. Signature of Funeral Servica Licensee SKILES FUNERAL HOME EMMITSBURG, MD. 21727 210 WEST MAIN STREET 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** UREMIC SYNDROME /Medical Immediate Ceuse (Finel disease or condition resulting in death) **Examiner** Examiner physician and the buriel-transit that the death certificete be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events rasulting in death) Lasi Due to (or as a consequenca of): Division of Vital Records, P.O. Box 68760, lan/Medical Due to (or as a consequence of) ettending p Physici signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Part I. 3 Probably 4 Unknown 1 ☐ Yee 2 ☐ No þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 has 2 No Yes 2 No certificate Hospital or Attending Physician: director. 25. Wes case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 9 1 Yes 2 No Te impatient 2 ER/Outpetient 3 DOA this funeral 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation Injury death. efter deatl 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) in by 4 Homicide within 24 hours effort To the Funeral Discompletely filled in Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, and due to the cause(s) and manner es stated.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) \$ 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of cartifier 29c. License number 0 31. Date tiled (Month, Dey, Year) 32. Registrar's Signature State MAY 17 1999 Registrar

DHMH 16 Rev 6/95



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) **Physician** ames /Medical 4a. Fecility Nama (If not institution, giva street and number) Examiner PENINSULA REGIONAL MEDICAL CENTER 5. Social Sacurity Number 7. Aga (In yrs. last birthday) **Funeral** 1 M 2□ F Hours Days 220-30-4630 Director Usual Rasidance of Decedant with the Maryland 10b. County 10c. City, Town or Location Funeral Director Somerse 10e. Street and Number 10f. Zip Code ò 238

2. Data of Death Month	Dey	1999	3. Tima of Deal
4b. City, Town, or Location of Death SALISBURY	4c. C	ounty of Death WICOM	ICO
ar If Lindar 24 Hrs 9 Date of Dist	-	0.00	

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72 KRS

(Month, Day, Year) Min. 2/17/31/ 10d. Insida City Limits 1 Yes 2 No 10g. Citizan of What Country?

P.O. 21817 12. Was Decedent Evar in U,S. Amed Forcas? 1 XYas 2 ☐ No 11-9-SI If Yes, Give Was Decedant of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - Amarican Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1□ Yas 20 No Specify: 3 ☐ Widowad 4 ☐ Divorced 6-6-54 Year or Datas:

Black 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Dacedant's Education (Specify only highast grade complated) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) 8+h grade 17. Fathar's Nama (First, Middle, Last) Seatoog -driver 18. Mothar's Name (First, Middla, Malden Surnama)

Boggs -4ther HNNie laylor 19a. Informant's Name/Relationship (Type, P. O. Box 45 Crisfield, Md. 21817

Crisfield 20b. Place of Disposition (Nama of cematery, cramatory or other place) 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata

Md. Veteraus Cemetary 5-20-99, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funarai Sarvice Licensas 22. Name and Addrass of Facility / Bennice Figure

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234. Part 1. Enter the disease, or compilcations that caused tha death. Do not antar the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one ceuse on each line. Approximate Onset and Death

tmmediete Ceusa (Finel CARDIO - RESP disease or condition resulting in daath)

Due to (or as a consequance of)

Saquantiatly list conditions, if any, leading to Immediate cause. Entar Undarlying Causa (Disease or Injury that initieted events rasulting in death) Last

Dua to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

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24a. Was an autopsy performed? ANDRIC EN CEPHALE PATHY

24b. Wara autopsy findings available prior to completion of cause of death? M/O CAASIAL 1 Yas 2 No 1 ☐ Yas 2 ☐ No

25. Was case refarred to medical 26. Placa of Daath (Check only one) Hospitat: 1 Inpatiant 2 ER/Outpalient 3 DOA 1 Yes 2 No Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify)

27. Mannar of Death 28c. tnjury et Work? 28b. Tima of 28d. Dascribe how Injury occurred 1 Netural

5 Pending invastigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not ba determined 3 C Suicide 28a. Place of tnjury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rure! Route Number, City or Town, Stata)

29a. Certifier

10 Certifying Physician: To the best of my knowledge, deeth occurred et the tima, deta and place, and dua to the cause(s) and menner es stated.
2 Medical Examiner: On the base of axamination end/or invastigation, in my opinion, deeth occurred at the tima, data and place, and dua to the cause(s) and manner stated. (Check only

29b. Signature and title of sertifier 29d. Date signed (Month, Day, Year) 29c. Licensa numbar 09

person who complated cause of deeth (Itam 23a) (Type, Print) Gragora Mampson 100 E. CAROLL ST m.0. PRMC Day, Yaer)

32. Ragistrar's Signature

State Registrar

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Maryland

Baltimore,

Box 68760,

P.O.

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Division of Vital

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Physician/Medical

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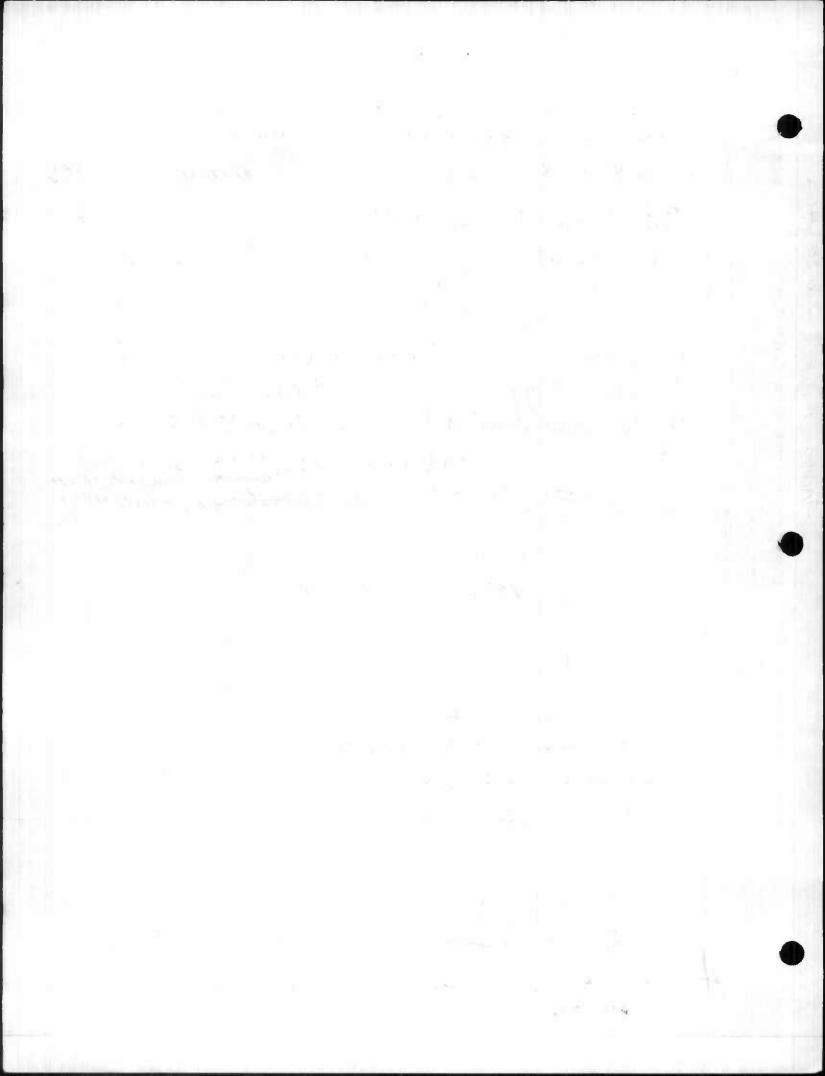
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Day **Physician** MAY 13,1999 3:00 A.M. Catherine Elizabeth Thomas /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sacred Heart Hospital Cumberland
If Under 24 Hrs.
Hours Min. Allegany 5. Social Security Number 7. Aga (In yrs. last birthday) If Under 1 Year 6. Sax Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F Months Yrs. Director 212-38-5651 09-Jul-08 Maryland Usual Residence of Decedent the Manyland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Allegany Frostburg 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 6 92 Ormand Street Nems 23s death Funerai 21532-J.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 210 No Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, Whita, etc. filed within 72 hours after. Hygiene. Wher then "natural", or fte 1 Nevar Married 2 Married Baitimore, Maryland 21215-0020 Specify: White 1 Yes 2 No If Yes, Give Year or Dates: Specify p 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filed w.
Department of Health and Mental Hygien.
Important: if Nem 27 is marked other tha
any Injury or other traumatic acceptance. 12 school principal education 17. Fathar's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Be **Harry Thomas** Elizabeth Johns 19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) **Bill Thomas** Frostburg Maryland 21532-96 Ormand Street 20b. Place of Disposition (Nama of cematery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) Frostburg Memorial Park 15-May-99 Frostburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility boku were Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each lina. Approximata intarval Between Onset and Death **Physician** /Medical Immediata Causa (Final disease or condition resulting in death) Examiner Examiner physician and the burial-transit be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Box 68760 Physician/Medical Due to (or as a consequence of) 950 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown signed b Records, þ 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? The lew page 2 1 ☐ Yas 2 No certificate Division of Vitai Hospital or Attanding Physician:
 124 hours after death.
 Funeral Director: After this certifics. director 25. Was casa referred to medical examiner? Be 26. Piace of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 1 Yes 2 No Certification: To 1 Nnpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. tnjury at Work? Natural 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. Medicai 29a. Certifler To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number un MAY 1999 30. Nama and address of person who completed cause of death (item 23a) (Typa, Print) nus 48 Tarn Terrace, Frostburg, MD, 21532 31. Data filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 4 1993

DHMH 16 Rsv 6/95

Registrar

Catherine Eurabeth Thomas

Allegany Sacred Heart Hospital Cumberland

212-38-5651 90 09-Jul-08 Maryland

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92 Ormand Street

21532-U.S.A.

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Elizabeth Johns Hony Thomas

% Ormand Irrest Frostburg Maryland 21532-Bill Thomas Brother

Frestburg Niemonal Fank 15-May-99 Frostburg, Maryland

Durst Funeral Home, 57 frost Ave., Frostburg, MD 21532

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day Vosi 13 99 4c. County of Death Robert Norris 4b. City, Town, or Location of Death Taylor 11:50 AM 4a Facility Nama (If not institution, give street and number) 30739 Antioch Ext. Somerset Princess Anne If Undar 1 Yaar If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. lest birthday) 8. Date of Birth (Month, Day, Yaar) Birthplace (Stata or Foreign Country) Days Hours Months 1 € M 2 □ F August 27, 1937 219-34-3760 Wenora, Maryland Usual Rasidance of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 XNo Somerset Princess Anne 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 30739 Antioch Ext 21853 USA 14. Race - Amarican Indian, 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 Ø No If Yes, Giva Yaar or Datas: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) Black, Whita, atc. 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yas 2X No Specify: Specify: White 3 ☐ Widowed 4 € Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) Collaga (1-4or 5+) 10 Delivery Driver Pizza Plus 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Norris Taylor Elizabeth Abbott 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rurel Routa Number, City or Town, State, Zip Coda) Elsie Thornes/Daughter 20b. Place of Disposition (Name of camatary, cramatory or other place) Apt. 4, Fruitland, MD 21826 20c. Location - City or Town, Stata 20a. Method of Disposition 1 ☐ Burlal 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Cremation 5/15/99 Salisbury, Maryland 21. Signature of Junaral Sarvica Licensaa 22. Nama and Addrass of Facility M01051 Holloway Funeral Home, Professional Association 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. MD 21804 Approximata Intarval Between Onset and Daath Immediata Causa (Final disaasa or condition resulting in deeth) a years. Due to (or es a consequence of): Dua to (or as a consequence of): Dua to (or as a consequence of) 23b. Did tobacco uas contributa to the cause of death? 15 Yes 2 No 3 Probably 4 Unknown

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. Stata

MD

**Funeral** 

Director

than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at

2 should be filed within 72 hours after deeth with end Mental Hygiene. Is marked other than "naturel", or itema 23a or

Pages 1 and 2 should be nent of Health end Mental

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permit. Pages 1 and 2 Department of Health e Important: If Item 27 is any injury or other trai

Baltimore, Maryland 21215-0020

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Division of Vital Records,

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Examiner The law requires that the death certificate be executed Physiclan/Medical ģ Completed or Attending Physician: after death. Director: After this certifice Be 2 Certification: the Funeral Direction of the Funeral Direction Hospital

> State Registrar

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Sequentially list conditions, if any, laeding to immadiata ceusa. Entar Undarlying Causa (Disaasa or Injury that Initiated avants rasulting in daath) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were eutopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? 1 Yas 20 No 2 No 1 Yas 25. Was case referred to medicel axaminar? 26. Piaca of Death (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yes 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 28e. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28d. Dascribe how Injury occurred 28c. Injury at Work? 5 Pending investigation 1 Netural 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be daterminad 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, Steta) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as stated.
2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. 29a. Cartifiai (Check only

29c. Licansa number

29d. Data signed (Month, Day, Year)

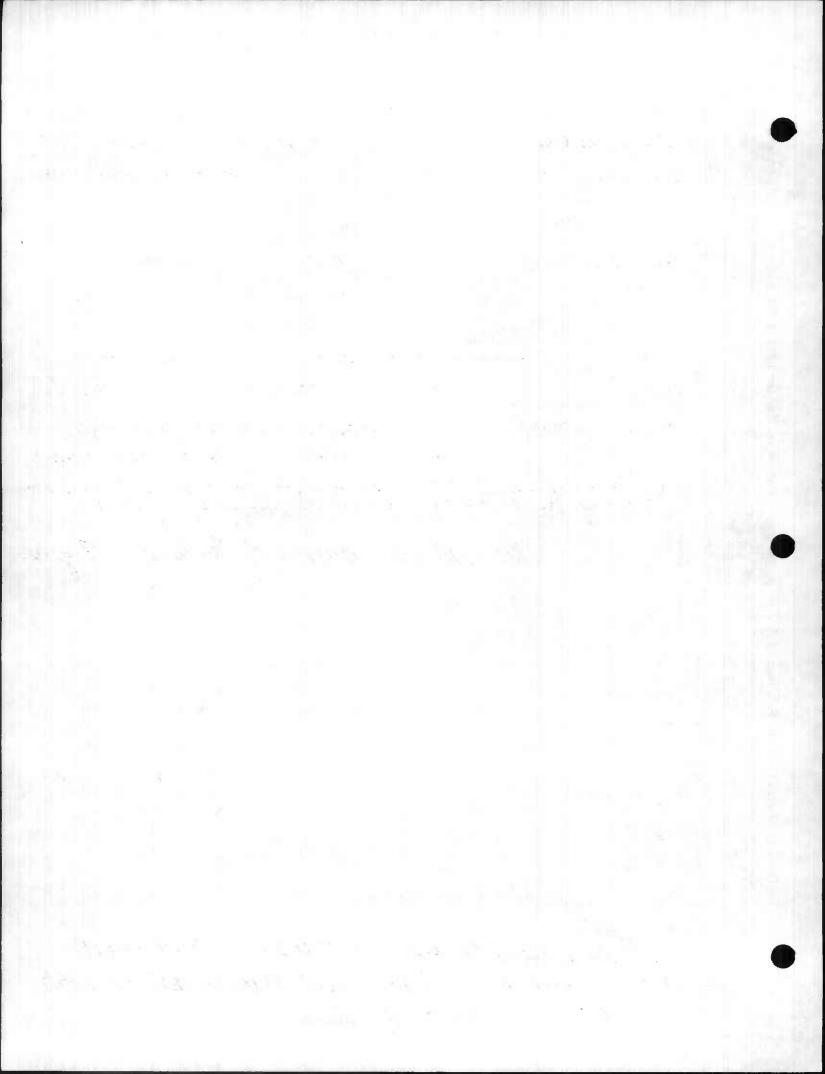
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**DHMH 16 Rev 6/95** 



Box 68760

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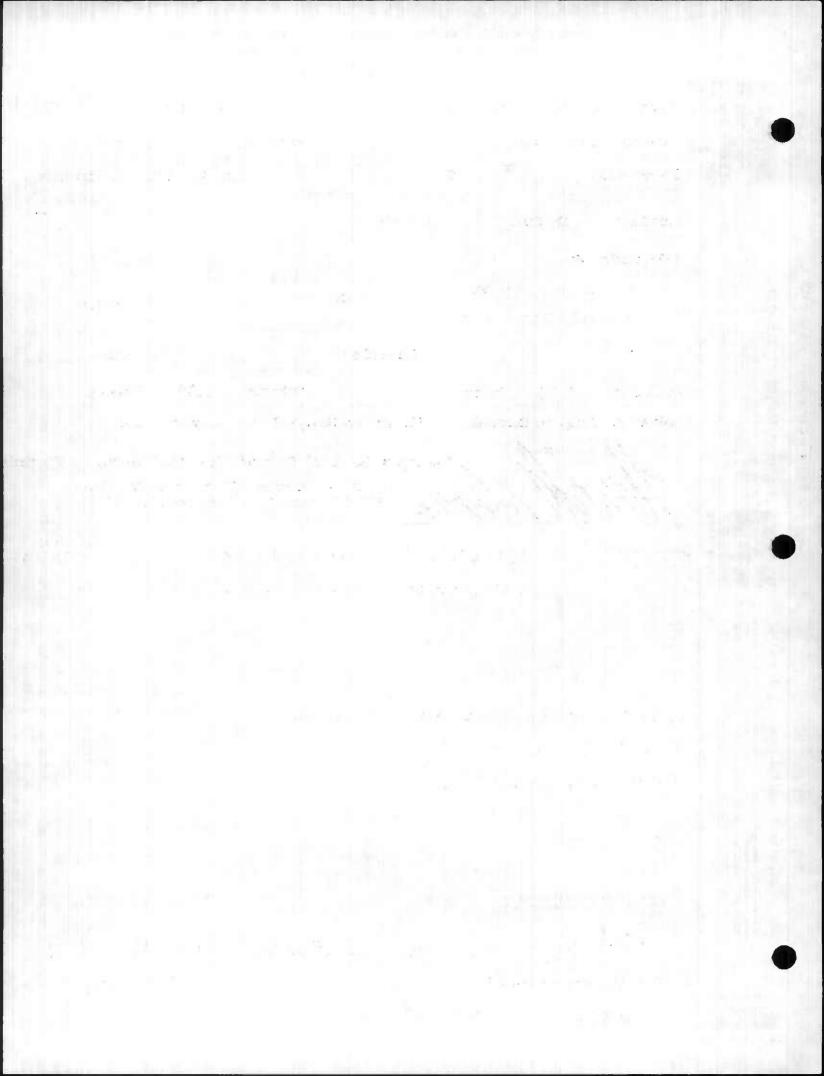
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** MAY 2:25 PM 1999 14 WILDA **JEANETTE** THOMPSON /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Fallston General Hospital Fallston Harford If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1□M XXE Days Hours Yrs. Director 236-86-1090 86 June 22, 1912 W. Virginia Usual Residence of Decedent tha Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f shot insumatic svent, the Medical Examiner must be notified at 1 ☐ Yes 2XXX0 Directo Maryland Harford Bel Air 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1116 Harlon Way Funeral 21014 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ※XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian. 11. Maritel Status Black, White, etc. 1 Never Married 2K Married 1 ☐ Yes XX No Specify: þ 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Namis (First, Middle, Maiden Surname) and Mental I Jefferson Octavia (u/k)(u/k)Plumley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 ment of Health ant: If Hem 27 I Delmar H. Thompson-Husband 116 Harlon Way, Bel Air, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Cremation 3 MRegraral from State ö Department Important: It 5 Other (Specify) Dunningham Memorial Park 5/20/99 St. Albans, W. Virginia 22. Name end Address of Fecility Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 that the mode of dying, such as cardiac or respiratory errest, Approximate Intervel Between Onset and Death **Physician** SEVERAL ISCHEMIC CARDIUM TOPATHY /Medical mmediate Ceuse (Final MONTHS disease or condition resulting in death) **Examiner** Examiner CORDNARY ARTERY DISEASE physician and s tha burial-trans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequence of) that the death cartificate be Physician/Medical Due to (or as e consequence of) Usa as I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uea contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown GASTROINTESTINAL BLEEDING signed t Completed by 24b. Were autopsy findings aveileble prior to completion of cause of death? 24a. Was en autopsy HIPERTENSION has DIABETES MELLITUS 1 ☐ Yes 2 PNo 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P<sub>C</sub> this funaral 27. Menner of Death 28d. Describe how Injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? Certification: 1 Netural 5 Pending 1 Yes 2 No daath. investigation 2 Accident or Attendation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and menner stated. edicai 29a. Certifier To the Hosp within 24 hor To the Fune complately fi (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BELARK MD 21014 YAMKAR VORTH 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 8-1999 Registrar

DHMH 16 Rev 6/95



**Funeral** 

Director

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7 is marked other than "natural", or flams 23s or 28s-f show trsumatic event, the Medical Examiner must be notified at

# death altimore, Maryland 21215-0020 al Hygiene. permit. Pages 1 and 2 should be filk Department of Health and Mental Hy important: if item 27 is marked oth any liqury or other traumatic event potes.

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Physician /Medical Examiner ed by the attending physician and detached for use as the bunal-transit signed by t d be detach

Box 68760. P.O. Division of Vital Records.

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To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3 Time of Death CLENN ALTA TANNER 1999 May 13, 1:00 AM 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Hart Heritage Harford Street If Under 1 Year Months Devs If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Dete of Birth (Month, Dev. Year) 9. Birthplace (State or Foreign Deys Hours 1⊠ M 2□ F Aug. 24, 1917 California 572-05-8210 81 Usuel Residence of Deceden 10e Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Harford Abingdon 1 Yes 20 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 311 H. Laurel Woods Dr. 21009 USA 12. Was Decedent Ever In U.S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. 11. Merifal Stefus Bleck, White, efc. 1 Yes 2 No If Yes, Give Yeer or Dates: WWII 1 ☐ Never Merried 2 ☑ Married 1 ☐ Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupeflon (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Lt. Col. Supply & Security Div. U.S. Government 5+17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Alta Roy Tanner Bertha May Naftel 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 311 H. Laurel Woods Dr., Abingdon, MD 21009 Ada Belle Tanner/ Wife 20b. Placa of Disposition (Neme of cametery, cremetory or other pleca) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Buriel 2 X Cremation 3 ☐ Removel from State 5-13-99 4 ☐ Donetion 5 ☐ Other (Specify) Hilltop Service Corp. Towson, Maryland 22. Name end Address of Facility Howard K. McComas III Funeral Home, P.A. 23a. Pert1. Enter the disease, or complication of the Laused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest,

April 23a. Pert1. Enter the disease, or complication of the Laused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest,

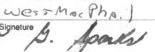
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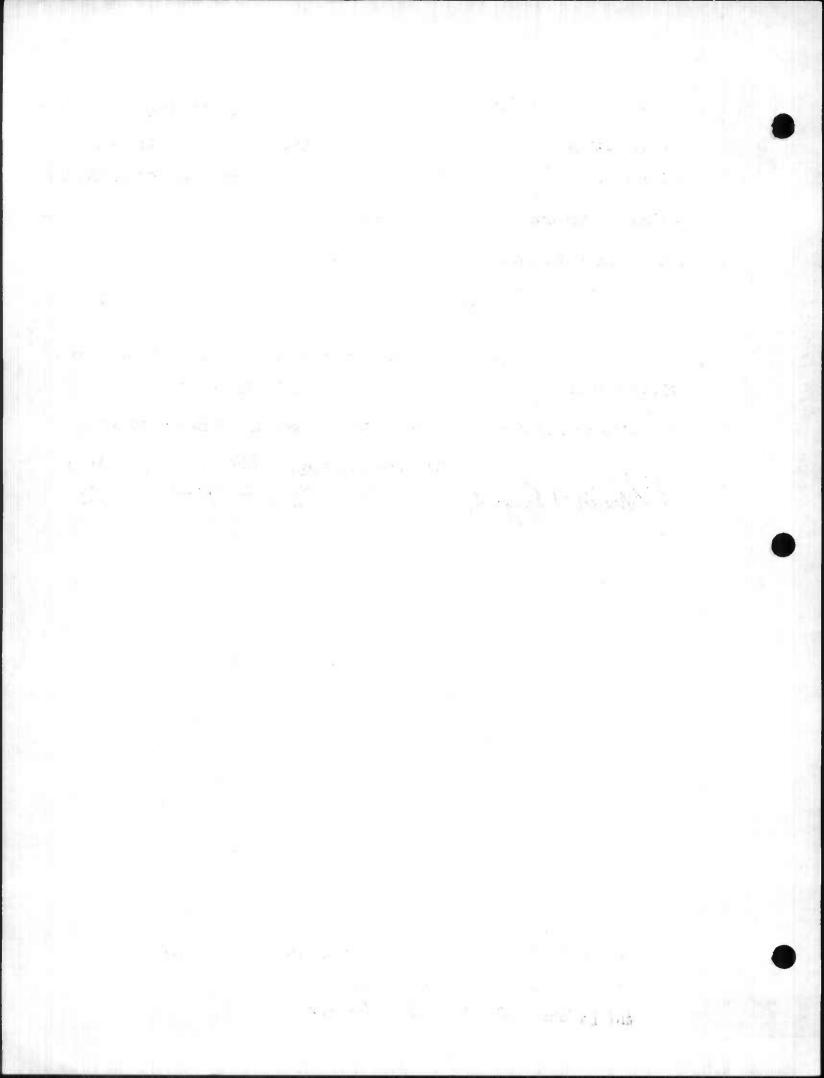
April 23a. Pert1. Enter the disease, or complication of the Laused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Interval Between Onsef and Deeth Immediate Cause (Finel disease or condition resulting in death) Due to (or as a consequence of) Examiner < 2 Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Physician/Medical thet initieted events resulting In deeth) Lest Due to (or as e consequence of) Part ff. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Dfd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior fo completion of cause of death? 24a. Wes an autopsy performed? Completed 2 No 20 No 1 ☐ Yes 1 Tyes 25. Was case referred to medical examiner? Be 28. Place of Death (Check only one) 1 Yes 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: AN Nursing Home 5 Residence 8 Other (Specify) 2 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Phyercian: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, dete and piace, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signeture and tifle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 13, 1755 032297 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

31. Dete filed (Month, Dey, Year) MAY 1 4 1999

BAU, D

5. DUNN 32 Registrar's Signeture





#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

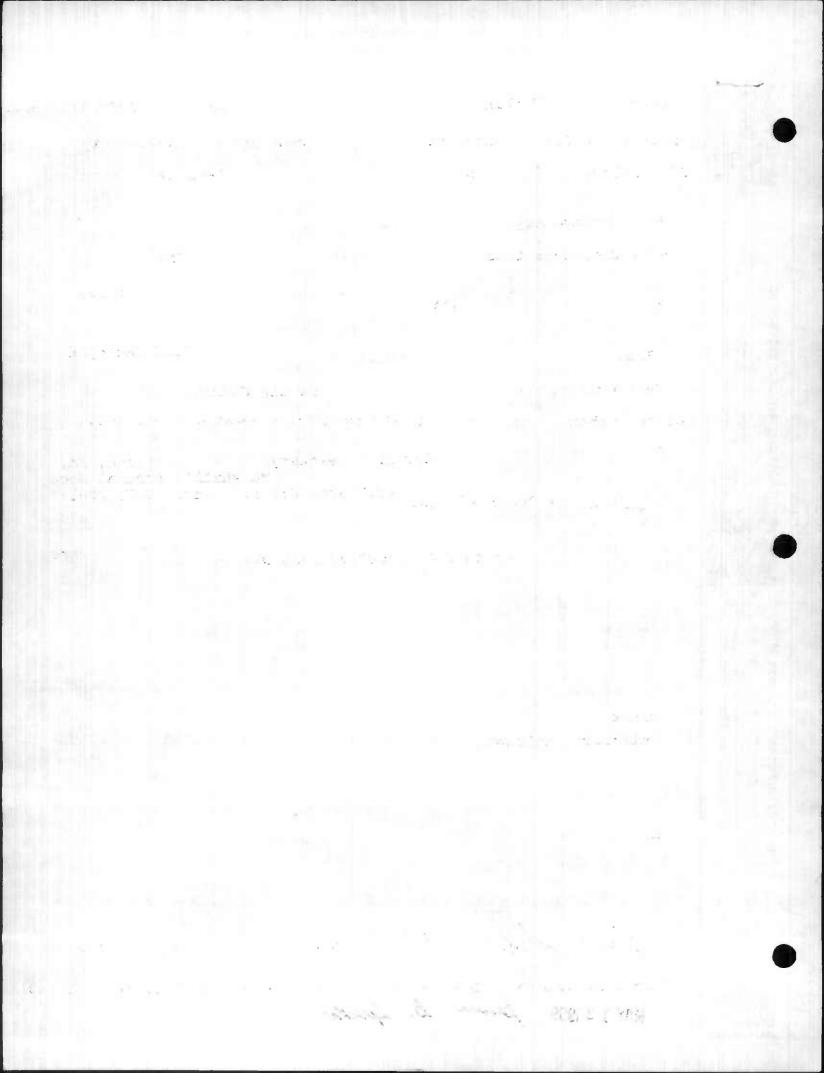
	A.  Hospital Sax 1 A.  12. Was Decedent E. Armed Forces? 1 LAYes 2 No. H Yes, Give Year or Dates: 1  ducation ada completed) College (1-4or 5+	Hur Hur ver in U,S. 922–24	rs. Months Day	4b. City, Town, or L  Prince F  If Undar 24 Hrs. S Hours Min.  Hours Min.  Hispanic Origin? (Sriban, Mexican, Puerto o Specify:	ocation of Death rederick 8. Date of Birt (Month, Da) Mar. 14	8, Pay 99  4c. County  Calv  th, Year)  4, 1904	ert 9. Birthplecs (State or Foreign Country)  Maryland  10d. Insida City Limits 1 Yes 2 No  What Country?  9. American Indian, kk, White, etc.
Calvert Memorial Social Security Number 6. State 10b. County aryland Calvert De. Street and Number 1011 Mary Circle 1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced (Specify only highest gr. Elementery/Secondary (0-12) 8th 7. Fathar's Name (First, Middle, Last Fendall V 9a. Informant's Name/Relationship (	HOSPITAL  Sax 1 7. Age 1 M 2 F  12. Was Decedent Examped Forces? 1 Myes 2 New Year or Dates:  College (1-4or 5+	10c. City, Town Hur yer in U,S. 922–24	If Under 1 Yea Months Day  or Location  10f. Zip Code  2063  13. Was Decedent of ff Yas, specify Cu  1 Yes 3000	4b. City, Town, or L  Prince F  If Undar 24 Hrs. S Hours Min.  Hours Min.  Hispanic Origin? (Sriban, Mexican, Puerto o Specify:	ocation of Death rederick 8. Date of Birt (Month, Da) Mar. 14	4c. County Calv th y, Year) 4, 1904  10g. Citizen of V USA 14. Race Blace	of Death  ert  9. Birthplece (State or Foreign Country)  Maryland  10d. Inside City Limits  1 Yes 2 No  What Country?  9 - American Indian, kk, White, etc.
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							land 21666
		20b. Place of	Disposition (Name of	Ţ	Date		City or Town, State
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VHATT Aub			400				m MD 21027
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snock, or neert tellure. List only	one cause on each line						Onset and Death
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Hy perte	ension				24a. Was perfo	an autopsy ormed?	24b. Were autopsy findings available prior to completion of ceuse
							of death?
C Maria and a second and a second and	T						1 ☐ Yes 2 ☐ No
examiner?	Hospital:			Other:			(C
7. Menner of Deeth			ime of 28c. fn	jury et			
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3 ☐ Suicide 6 ☐ Could not b	200. Place of Injur	y - Af home, fa (Specify)	rm, street, factory, offic	00	28f. Location ( City or To	Street and Numb wn, State)	per or Rural Route Number,
9a. Certifying Pl (Check only one) 2 Madical Exa	miner: On the basis of e	examinetion en	, death occurred at the d/or investigation, in my	time, date and place y opinion, death occu	, and due to the rred at the time,	date and place,	anner as stated. and due to the cause(s)
9b. Signature and title of	1 ,,		29c. Lica	nsa number		29d. Date signe	d (Month, Day, Year)
1	teld			00572	42	MAY	, 8, 1999
0. Neme and address of person who	completed cause of de	eth (Item 23a) (	Type, Print)			10	, 5/11/
JOSEPH J BARTH	III, M.D	)., PR	INCE FRED	ERICK, M	ID 2067	8	
1. Date filed (Month, Day, Year)	2 Registrar	's Signeture		11			
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DHMH 16 Rav 6/95

State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death	F	Reg. No.	1343
Towns of the second	Decedant's Nama (First, Middla, Last)	2. Data of Das Month		3. Time of Death
Physician /Medical	James Watkins	May	6	1999 1:30 a.i
Examiner	4a Facility Nama (If not Institution, give street and number)  4b. City, Town, or L	Location of Death	4c. County	of Death
40	Mariner Health of Bethesda Bethes		Monte	gomery
Funeral Director	5. Social Sacurify Number 243-05-7198 6. Sax 125M 2DF 84 7. Aga (In yrs. lest birthday) 1 Months Days Hours Min.	8. Data of Birth (Month, Day 8-14-		9. Birthplaca (Stata or Foreign Country) Georgia
show show	Usual Rasidenca of Decedent  10a. Stata 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☑ Yas 2 ☐ No
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ifier death with the Maryland ifier death with the Maryland internstate by notified at Funeral Director	10e. Street and Number 10f. Zip Coda 20814		10g. Citizen of V	Vhat Country?
020 urs after ur, or he	If Yas, Giva 10 41 □ III Yas 2 № No Specify:	pecify Yas or No- o Rican, atc.)	Blac	e - American Indian, k, Whita, atc. : Black
5-002 72 hours natural', old a fee	15. Decedant's Education 16a. Decedant's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work done	rkina	16b. Kind of Bu	sinass/Industry
3 within jiene.	(Specify only highest grade completed)  Elementary/Secondary (0-12)  3rd.  (Giva kind of work done during most of work file. DO NOT use ratired)  Roofer		Self E	mployed
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fary 2 short and N is man	19e. Informant's Name/Ralationship (Type, Print)  19b. Mailing Address (Street and Number or Ru			Steta, Zip Coda)
E TO N L	Diane Gerber Guardian 10100 Ashwood Drive 1	Kensingt	on, MD.	20895
of Health	20a. Method of Disposition  20b. Placa of Disposition (Nama of cematary, cramatory or other place)	Data	20c. Location -	City or Town, Stata
y or	1X Buriel 2 Cramation 3 Removal from State 4 Donation 5 Other (Specify)  Cedar Hill Cemetery	5-10-99	Suitl	and Md
프 교육원은	21. Signature of Funaral Sarvice Licansaa 22. Nama and Addrass of Facility Ma	arshall	's Fun	eral Home
Depa Depa Impo	Q Q 20 1 4217 9th. St. N			
	23a. Part   Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock or heart feilure. List only one cause on each line.	c or raspiratory ar	rast,	Approximata Interval Between Onsat and Daath
Physician /Medical Examiner	Immediate Causa (Final disease or condition resulting in death)  a. Chronic Obstructive Lung Di  Due to (or as a consequence of):	_sease_		years
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Division To the Hospital or Attendinwithin 24 hours after death. To the Funeral Director: All completely filled in by the fur Medical Certification	29a. Certifier (Check only one)  1   Cartifying Physician: To the best of my knowledge, daath occurred et the tima, data and place (Check only one)  1   Cartifying Physician: To the basis of examination and/or investigation, in my opinion, deeth occurred et the tima, data and place (Check only one)	e, end due to the urred at the time,	causa(s) and ma dete and piece,	nnar as stated. and due to the ceuse(s)
o the omple omple	29b. Signature and little of comber 29c. Licansa number		29d. Data signe	d (Month, Day, Year)
11	I fre file 140 20516		May 11	, 1999
(4)	30. Name and eddrass of person who completed ceuse of death (Itam 23a) (Type, Print)  Joel R. Schulman MD FCCP 9410 Old Georgeto	own Rd	Betho	eda MD 2001
State Registrar	31. Data filed (Month, Day, Year)  MAY 1 2 1999  32. Registrar's Signatura  Apacla	- 1111 ING	Decine	.bdd, Fib. 2001

DHMH 16 Rev 6/95



# Please Type or Print In Black Indelible Ink. Assure Ali Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

dical dical	1. Decedent's Name (First, Middle, Las JULIA LEE WOOLAR) 4a Fecility Name (If not Institution, give SOUTHERN MARYLAN) 5. Social Security Number 577–54–4127  Usual Residence of Decedent 10a. State 10b. County  Maryland Prince G	D HOSPITAL  D HOSPITAL  A Age  7. Age	(In yrs. last birthday) 70 Yrs.	If Under 1 \\ Months D	CLINTO	s. 8. Date of Bir	PRINCE		2:04 pm
Olrector .	SOUTHERN MARYLAN  5. Social Security Number 577-54-4127  Usual Residence of Decedent 10a. State 10b. County	D HOSPITAL PX 7. Age DM 2X F	(In yrs. last birthday)		CLINTO	N	PRINCE		GE'S
Director	5. Social Security Number 577–54–4127 10  Usual Residence of Decedent 10a. State 10b. County	ox □M 2⊠F	(In yrs. last birthday)		rear If Under 24 Hi			E GEORG	GE'S
Director	577-54-4127  Usual Residence of Decedent 10a. State 10b. County	□M 2⊠F				O. Date of Dil		0 Righolas	
Director	10a. State 10b. County	т				July 17,	1928	Country, William	ston, N.C
al Director	Maryland Prince G		10c. City, Town or Lo	cation			THE ST	10d.	inside City Lim
al Dire		George's	Temple H	i11					1 <b>X</b> Yes 2□
- C	10e. Street and Number			10f. Zip Co			10g. Citizen of V		?
-	6819 West Chester				20748	Canality Van on Na	U.S.	A . e - American	Indian
	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Yes 220 No If Yes, Give Year or Dates:	)	f Yes, specify	t of Hispanic Origin? Cuban, Mexican, Pue No Specify:	rto Rican, etc.)	Blac	k, Whita, etc	
1	15. Decedent's Edi		16a. Deced	lent's Usual C	ocupation	nd:ina	16b. Kind of Bu	ısınass/îndus	stry
	(Specify only highest grad	College (1-4or 5+	·)		done during most of w etired)	Orr.nig			
-	11th 17. Father's Name (First, Middle, Last)	·	Hor	memakei		ame (First, Middle,	Priv		
	Walter Scott					a Robins		-,	
1	19a. Informant's Name/Ralationship (T	ype, Print)	19b. Mailir	ng Addrass (S	treet and Number or i	Rural Route Numb	er, City or Town,	Stata, Zip Co	oda)
	Deborah Woolard/D	aughter	6819 W	est Ches	ter Court, T	emple Hill	, Maryland	20748	
	20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ I	Removal from State	20b. Place of Dispo cemetery, cren	natory or othe	r place)	05/17	20c. Location -	City or Town	, State
	4 ☐ Donation 5 ☐ Other (Specify,	)			nal Cemeter	y 1999	Arlingto	on, Vi	rginia
	21. Signature of Funeral Service Licens	See			ddress of Facility VKINS FUNE	RAL HOME			
edical Examiner	Immediate Cause (Final disease or condition resulting in death)	. Acut	Myo (	and quanca of):	al u	forct	ion		terval Batween nset and Death 2 HRS
	Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated evants resulting in death) Last	C	hulmona be to (or as a conseque to (or as a conseq	ivence or):	rrest				min
		d							
	Part II. Other eignificant conditions co	ntributing to death but	not resulting in the u	nderlying caus	se given in Part f.	23b. Dld	tobacco use co	ntribute to th	ne cause of dea
						10	Yes 2 No	3 Probet	bly Munkin
Constantinos							an autopsy ormed?	avalle	autopsy finding able prior to detion of cause ath?
						10	Yes 2 No	101	res 2□ No
	25. Was case raterred to madical examiner?	Mosnital:				eath (Check only	one)		
	27. Manner of Death	Hospital: 1 Inpatien 28a. Date of Injury (Month, Day	28b. Time of	28c.	Injury at Work?	Home 5 ☐ Resi 28d. Describe	dence 6 Oth how injury occur		
	2 Accident investigation 3 Sulcide 6 Could not be	28e. Place of Injurbuilding, etc.	ry - At home, farm, str (Specify)	M eet, factory, o	1 Yes 2 No	28f. Location ( City or To	Streat and Numb wn, State)	per or Rural F	Route Number,
	4 ☐ Homicide determined	(Check only 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occ				ne and due to the	fue to the causa(s) and man the time, date end place, ar		ed.
	4 ☐ Homicide determined  29a. Cartifiar	raician: To the bast of iner: On the basis of e and manner stat	examination end/or inv	occurred at t vestigation, in	he time, date and pla my opinion, death oc	curred at the time,	date end place,	and due to th	ne cause(s)
	4 ☐ Homicide determined  29a. Cartifiar (Check only) 2 ☐ Medical Exam	fner: On the basis of e	examination end/or inv	vestigation, in	he time, date and pla my opinion, death oc icense number	curred at the time,	date end place, 29d. Date signe		
Medical Certification:	4 ☐ Homicide determined  29a. Cartifliar (Check only one)  Check only 2 ☐ Medical Exam	fner: On the basis of e	examination end/or inv	vestigation, in	my opinion, death oc	curred at the time,	date end place,		

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	ID THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the host	THE FUNERAL DIRECTOR: After this cardificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached anything 20 peace after death with the Case of the Complete Comp	or men when it made a deal wan he can copy, or reads any injury, or other traumatic event, the medical examiner must be notified at once,
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end	# 6 Per FH PGC 5- 1 - STATE REGISTRAR	-14-99 cr STATE OF MA	ARYLAND / D	EPARTM	ENT OF H	IEALTH AND DEATH	MENTAL HYGIE	NE	,	
Ý	1. DECEDENT'S NAME (First, Middle, Last)  JOYCE WESTRY		- OLI		AIL OI	DEATH	2. DATE OF DEATH MONTH	DAY 12	YEAR 3	B. IJAM M
	4. SOCIAL SECURITY NUMBER 245-42-25-43	1   M 2   F	B. AGE (In yrs. lest bl		UNDER 1 YEAR ITHE DAYS	IF UNDER 24 HRS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 11/24/19	932	Country)	ACE (State or Foreign
TOR	90. FACILITY NAME (If not institution, give standing of December 1988)  RESIDENCE OF DECEMENT		ie	9b.	Clint	PR LOCATION OF	DEATH	100	UNTY OF DEA	
DIRECTOR	10a. STATE 10b. COUNTY	e George'		Oc. CITY, TO	Clini					0d. INSIDE CITY LIMITS?  X YES 2 NO
FUNERAL	100. STREET AND NUMBER 7520 Surratts				101	ZIP CODE	735	10g. CI		AT COUNTRY?
B⊀	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT, FORCES? 1.0 IF YES, GIVE WAS	YES 2 NO	D	If yes, sp	ENDENT OF HISP ecify Cuben, Mex 2 X NO Spe	PANIC ORIGIN? (Specify ) ican, Puerto Rican, etc.) offy:	es or No-	14. RACE - Black, 1	- American Indian, White, etc. BLACK
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	CATION completed)  College (1-4 or 5 +)  1 YR.	Itte. Do	NOT use ret	AL OCCUPATION done during moired.) ASSIST	st of working	166. KIND OF B			ry
BE CON	17. FATHER'S NAME (First, Middle, Last) Janatus Taybron					Cat	NAME (First, Middle, Maide therine Sar	ders		
10	190. INFORMANT'S NAME (Type/Print)  Janatus Taybron,	JR. / Br					Ct. Ft. V			MD 20744
	20e. METHOD OF DISPOSITION  1		20b. PLACE AND COMMENT ROCKY		TO CEMI	ETERY	5-17-99	ROCI	KY MOU	NT, NC
	21, SIGNATURE OF FUNERAL SERVICE LIC	& ma	Xfon		4308 8	Suitland		land	, MD	al Home 20746
	23. PART I. Enter the diseases, or o shock, or heart fellure. I IMMEDIATE CAUSE (Final disease or condition resulting in death)	Asp,	on each line.		onter the mo	de of dying, and	uch se cerdisc or res	piratory s	rrest,	Approximate Interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO D	OR AS A CONSEQUE	lere	Prot	euri	der ace	idr	l	6 houls
PHYSICIAN: MEDICAL C	PART II. Other significant condition	contributing to d	eath but not resu	ulting in th	e underlying	g ceuse given		PRMEDT	0	ERE AUTOPSY FINDINGS WAILABLE PRIOR TO OMPLETION DF CAUSE F DEATH?  YES 2 NO
SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO	HOSPITAL:	ER/Outpatient 3 🗆		HER:	ACE OF DEATH	Check only one)			
ву РНУ	27. MANNER OF DEATH  1 Netural 5 Pending 2 Accident Investigation	28e. DATE OF IN (Month, Day,	IJURY 2	Bb. TIME OF	28c. INJ WO		26d. DESCRIBE HOW	INJURY O	CCURED	
	3 Suicide 6 Could not be determined	28e. PLACE OF building, et	INJURY — At home, c. (Specify)	ferm, street	, factory, offic		281. LOCATION (Stree City or Town, State	t end Numbe e)	er or Rurel Rou	ite Number,
COMPLETED	29e. CERTIFIER (Check only one)  1 X CERTIFYING PHYSIC 2 MEDICAL EXAMINE						ue to the cause(e) end m			nd manner ee stated.
BE	296. SUNATURE AND TITLE OF CERTIFIER	MB	Allwa	lung		29¢ LICENSE N	UMBER 35	29d. DA	TE SIGNEO (M	Ionth, Day, Year)
5	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE	OLD BRAN	) (Type, Print	VE. CL	INTON	MD 20735			

boards

3. REGISTRAR'S SIGNATURE

31. DATE FILED (Morgh, Day, Year)
WAY 1 4 1999

STATE OF THE STATE

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician Harold Kenneth White 7, 1999 May 2130 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel General Hospital Annapolis If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) Anne Arundel 5. Sociel Security Number Birthplace (Stete or Foreign Country) 6. Sex 7. Age (In yrs. last birthdey) **Funeral** 1₺ M 2□ F Yrs. 80 Director 577-16-2868 Feb. 18, 1919 Virginia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is merked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 320 Colony Point Place 21037 United States death Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 M Yes 2 No If Yes, Give Year or Dates 1943-1946 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Black, White, etc. Pages 1 end 2 should be filed within 72 hours after onen of Health and Mental thygiene.

ment if them 27 is merked other than "natural", or itea into or other traumatic event, the Medical Engine iny or other traumatic event, the Medical Engine. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: p 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education 16a. Decedant's Usual Occupation 16b. Kind of Businass/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grede completed) College (1-4or 5+) Elementery/Secondary (0-12) Self Employed 6 Restaurant Owner 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Pauline A. Wheeler Randolph Howard White 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mildred M. White-Wife 320 Colony Point Place, Edgewater, Maryland 21037 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State permit. Page Department Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) 5-10-99 Brentwood, Maryland Fort Lincoln Crematory 21. Signature of Fureral Serviced Licenses 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, Maryland 20722 23a. Part1. Enter the disease, or colored cattons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** enebrovascular Accident Immediate Causa (Final disease or condition resulting In death) /Medical 4 days Examiner Examiner certificate be executed physician and s the burial-trans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Lest Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): 80 esn Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contributa to the cause of death? P.O. adetech 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown chronic obstructive pulmonary disease Records. 2 Sign Be 24b. Were autopsy findings available prior to completion of cause of death? Alzheimers dementia 24a. Was an autopsy Completed page 2 history of intermittent atrial fibrillation 1 Yes 2 No 1 □ Yes 2 □ No Division of Vital 25. Was cese referred to medical examiner?
1 ☐ Yes 2 ☑ No uneral director. Be 26. Place of Daath (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 27. Manner of Death 1 @Natural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? Certification: Attending 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not ba datarmined 28e. Place of Injury - At home, farm, straet, factory, offica building, etc. (Specify) 3 Suicide Location (Street end Number or Rural Route Number, City or Town, Stete) 4 - Homicide δ 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, daath occurred at tha tima, date and place, and due to tha cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Cartifiar edicai To the Hosp within 24 ho To the Fune completely f (Check only one) 29b. Signature end titled certifier 29d. Date signed (Month, Dey, Year) 29c. License number MD 5-8-99 D44161 30. Nama and addrass of person who complated cause of daath (Item 23a) (Type, Print)

Putricia Czapp, MD 900 Bestyute Rd Suite 303 Annapolis MD 21401 Va 32. Registrar's Signature 31. Date filed (Month, Dey, Year) State

DHMH 16 Rev 6/95

Registrar

MAY 1 0 1999

State of Maryland / Department of Health and Mental Hygiene

	Decedent's Neme (First, Middle,	Last)		Certificate	or Deatt	2. Date of Deat	eg. No. th	3. Time of Deal	th
Physician /Medica	AKMOLD	M. W	VERNER			May 9,	1999	7:47 AM	1
/Medica Examine	4a English Name // net hethylen		r)		4b. City, Town, or Bethesd	Location of Death	4c. County	of Death tgomery	
Funeral Director			Age (In yrs. last birt	hday) If Under 1 Y		s. 8. Date of Birth	Year)	Birthplace (State or For Country)     Poland	eign
2 .	Usual Residence of Decedent  10a. State 10b. County		10c. City, Towr	or Location				10d. Inside City Lir	- 24
with the Marylans a or 28a-f show the notified at		mery	Rockv			1.4	7.0	1√2 Yes 2□	
23a or 28a-f s wat be notified	I LOVI BASE JELLEL	son Street		10f. Zip Co 208			U.S.A.	What Country?	
OO20 hours after death urant, or flams 23 at Examiner must	3 ☐ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 X Yes 2 [ If Yes, Give Yeer or Dates	s? ]No		of Hispanic Origin? ( Cuban, Mexican, Pue No Specify:	Specify Yes or No- rto Rican, etc.)	Blac	e - American Indian, ck, White, etc.	
Maryland 21215-0020 d.2 should be filed within 72 hours at the and Mental Hygere. The marked other than "natural", or treatmetic event, the Medical Exami	15. Decedent's (Specify only highest Elementery/Secondery (0-12)	Education grade completed)  College (1-4or	(5+)	Decedent's Usuel O (Give kind of work of life. DO NOT use n ODERTY MA	ccupation lone during most of w etired)		16b. Kind of B	tate	
and other swent,				opercy na	7.7	arrie (First, Aliddle, A			
ylan ould be Mental arkad o					Mo11y	Moshin			
, Maryla and 2 should sath and Asia 527 is marken or traumatic	19e. Informant's Neme/Reletionship	p (Type, Print)			treet and Number or F				
	Florence Werner,	Wife			efferson S				
Baltimore, semit. Pages 1 ar separatinet of Hea important: if item. important: if item.	20a. Method of Disposition  Description 3  Donetion 5 Other (Spe		cometes	Disposition (Name of cremetory or other Lebanon C	emetery 5/11/			City or Town, State, Maryland	
Ball Permit Permit Import any in	21. Signature of European Service III	consoe	2		ddress of Fecility BREW MEMOR			E, INC. N, DC 20012	
Physician /Medical Examiner	23a. Perta-Parer the disease, or or sheek, or heert teiture. List or Immediate Ceuse (Final disease or condition resulting in death)	a.	Due to (or es e c	infar	ction	ac or respiratory arm	est,	Approximate Interval Between Onset and Death	10
Box 68760, eath certificate be executed attending physician and for use as the bunal-transit	Cause (Disease or Injury that initiated events resulting in death) Lest	c	Due to (or as a c		an cus			- A year	
O. B. B. death	Part II. Other algnificant conditions	s contributing to death	but not resulting in	the underlying caus	e given in Pert I.	23b. Did to	obecco use co	ntribute to the cause of de	ath?
S, P.O. Box es that the death cert goned by the attendin be detached for use						1 🗆 Y	es 2UNo	3 Probably 4 Unio	nown
ecords law require as been sig					_	24a. Was a perform	in autopsy med?	24b. Were autopsy findings available prior to completion of cause of death?	
						1 🗆 Ye	es 2ENo	1 Yes 2 No	
ARNOL FVItal I vaician: The vaician: The vai	25. Was case reterred to medical examiner?	Hospitel:			Others	eath (Check only on			
O £ 5 5	1 Yes ANO  27. Manner of Death 1 Meturat 5 Pending 2 Accident investige	tient 2 DER/Out jury 28b. T Dey Year) In	Injury at Work?  1 Yes 2 No	28d. Describe ho					
Division of Hospital or Attending P & hours after death. Funeral Director: After they filled in by the funeral dical Certification:	3 Suicide 6 Could no determine	28e. Pleca of le building, e	m, street, tectory, of	ffice	28f. Location (St City or Town	treet and Numl n, State)	ber or Rural Route Number,		
Hospi 24 hour Funer Puner Puner Mical			of examinetion and				due to the cause(s) and manner as stated. It the time, date and place, and due to the c		
To the comple		1		29c. Li	icense number	2	9d. Date signe	d (Month, Day, Year)	11
	Kenry	Roth	no	100	09946		5/9	7/99	
(10)	30. Name and address of person which is the sa	no completed cause of	death (Item 23a) (	1 / / /	roon St.	Rocks	rille.	ND 20852	
State Registrar	31. Date tiled (Month, Day, Year)  MAY 1 1 199		strer's Signeture	land	61				

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1. Decedent's Neme (First, Middle, Las	it)				2. Dete Mont		Dey	Yeer	3. Time of Death
Shirley A.	Weekl	Ley			May	10,	1999	9	7:15 pm
4e Fecility Neme (If not institution, give	street end number)			4b. City, Town,	or Location of	Death	4c. County	of Death	
	oad			Colmar	Manor		Princ	e Geo	orge's
5. Sociel Security Number 8. S		n yrs. lest birthdey)	If Under 1 Ye	ar If Under 24 I		of Birth h, Day, Y			ace (Stete or Foreign
579-38-0211 Usuel Residence of Decedent	□M 2X F	77 Yrs.	Months Dey	ys Hours M	June	13,	1921	Arka	
10a. State 10b. County	10	Oc. City, Town or Lo	ocation					10	d. Inside City Limits
Maryland Prince	George's	Colmar	1						1 Yes 2 No
			10f. Zip Code			100	Citizen of W		ry?
4209 Newark Road	1 12. Wes Decedent Eve	rin II S 13		722 of Hispenic Origin?	(Specify Ves	or No.	U.S.A	e - America	n Indian
4209 Newark Road  11. Meritel Stetus  1 X Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No		If Yes, specify C	uban, Mexican, P	uerto Rican, et	(.)		k, White, e	
3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Yeer or Detes:		1 ☐ Yes 2 N	lo Specify:			Specify	Whi	te
15. Decedent's Ed	ucation	16e. Dece	dent's Usuel Occ	cupetion	working	16	6b. Kind of Bu	isiness/Indu	ustry
15. Decedent's Ed (Specify only highest green Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use ref	ne during most of ired)	HUINING				
12	US. 290 (1. 401 04)		Clerk				I.R.	S.	
17. Fether's Neme (First, Middle, Last)				18. Mother's	Neme (First, N	iddle, Me	aiden Sumam	ie)	
James Howard	Weekley			Mar	-		Wright		
19a. Informant's Name/Relationship (7	Type, Print)	19b. Meili	ng Address (Stre	et a <i>nd Number</i> o	r Rurel Route I	lumber, (	City or Town,	State, Zip (	Code)
Robert D. Weekley				Court, U					
20e. Method of Disposition  1 X Buriel 2 Cremetion 3		20b. Pleca of Dispo cemetery, crea	osition (Neme of metory or other p	olece)	Dete	20	oc. Location -	City or Tow	vn, State
4 □ Donation 5 □ Other (Specify		Fort Lin			05/14/	99 ]	Brentwe	ood,	Maryland
@1. Signature of Funging Service Upon	500		2. Name end Ade						
1 1 1	(, )			uneral H					
23a. Part T. Enter the disease, or confi	DAIL LA LA		20 0014						
cost if any 1. street with organization or comp	Singlings That corregt the	47	ter the mode of	imore Av	enue, I	lyatt	sville		20781
shock, or heart tellure. List only o	plications that caused the one cause on each line.	Do nof en	ter the mode of o	imore Av	enue, I	lyatt ory erres	sville i,		Approximate Intervei Between
		Do not ent	ter the mode of o	tying, such es car	diac or respira	ory erres	it,		Approximate Intervel Between Onset and Death
Immediete Cause (Finel disease or condition		Do not ent	ter the mode of o	tying, such es car	diac or respira	ory erres	it,		Approximate Intervei Between
Immediate Cause (Finel disease or condition resulting in death)		Do not ent	ter the mode of o	tying, such es car	diac or respira	ory erres	it,		Approximate Intervel Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	e. ACUTE  Dut  COR	MY3 e to (or es e conse	CAR DI quenca of): AR I	tying, such es car	diac or respira	ory erres	it,		Approximate Intervel Between Onset and Death
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State of Maryland / Department of Health and Mental Hygiene

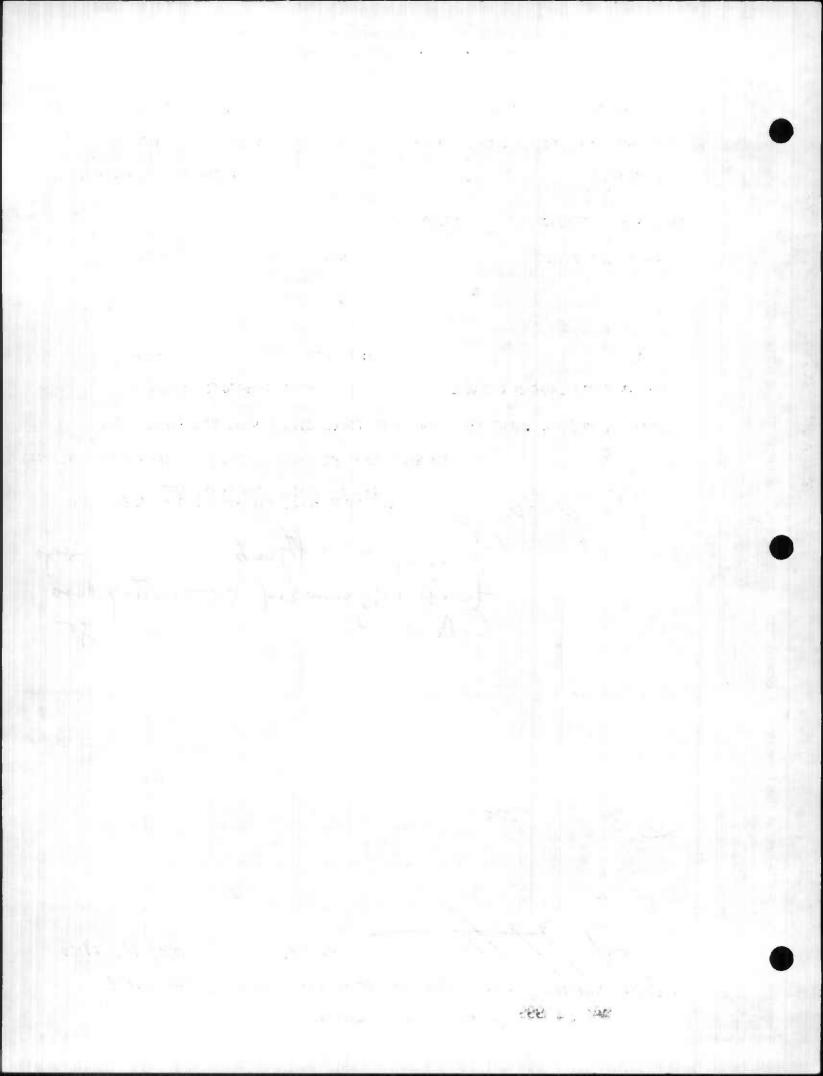
				Certific	cate of	Death		Reg. No.	99	1.7	349
	1. Decedent'a Name (First, Middle, L	ast)					2. Date of D		154	3. T	ime of Death
Physician /Medical	GEORGE HE	NERY WY	ATT						999		00 PM
Examiner	4a Facility Name (If not Institution, g	ive street and number,	)		4	b. City, Town, or	Location of Dea	th 4c.	County of		
	10031 Orchard R	oad			E	Berlin		W	orce	ster	
Funeral Director	5. Social Security Number 6. 220 12 1116	1 DAL OFF	ge (In yrs. last birt	hday) If U Yrs. Mon	nder 1 Year iths Days	If Under 24 Hrs Hours Min		ieth			State or Foreign
	Usual Residence of Decedent		10.00.00								
notified at	10a. State 10b. County		10c. City, Towr	or Location							side City Limits
cto cto	Maryland Worce	ster	Berlin								Yas 30No
other treumstic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	10e. Street and Number				. Zip Code					nat Country?	
edical Examiner must	10031 Orchard R	_			1811			U.S.			
by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces  1  Yes 2 V  If Yes, Give Year or Dates:	7		ecedent of H specify Cubs as 2XNo	ispanic Origin? (: in, Mexicen, Pue Specify:	Specify Yes or N rto Rican, etc.)	0-		- American Ind , White, etc. White	
Pe	15. Decedent's		16a.	Decedent's	Usual Occup	ation	orking	16b. Ki	ind of Busi	iness/Industry	
Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or	5+)			during most of wo					
lo Co	2		F	armer	^			Far	ming	3	
Be e	17. Father's Name (First, Middle, Las	it)					me (First, Middle	e, Malden	Sumame)	)	
10	John Wyatt					Emma	Lewis .				
	19a. Informant'a Name/Relationship	(Type, Print)	19b.	Mailing Add	dress (Street	end Number or F	lural Route Num	ber, City o	r Town, S	itate, Zip Code	)
4	Mary Ann Wyatt		1	0031	Orchar	d Road	Berlin	, Ma	rylan	nd 21	811
de de	20a. Method of Disposition		20b. Place of	Disposition			Date	-	-	ity or Town, S	late
5	1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		New H				5/19/99	Willa	ards.	Maryl	and
injury B	21. Signature of Funeral Service Lio	**		-	e and Addre					Stree	
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	11. Jule 10	ustale	du don Do				L-		, ME		
	23a. P. 111. Enter 17 disease, or co shock, or heart failure. List on	y one cause on each i	d the death. Do r ine.	ot enter the	mode of dylr	ng, such as cardia	ac or respiratory	arrest,		Inten	oximate val Between et and Death
ian	The second constant									Orise	n and Deam
cal ner	Immediate Cause (Final disease or condition	a CO	PD							MAN	Y YEARS
	resulting In death)		Due to (or as e	consequence	of):						
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Examiner	Sequentially list conditions,	J	Due to (or as a	consequence	of):						
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edicai	that initiated events resulting in death) Last	V	Due to (or as a c	onsequence	of):						
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by Physician/M	Part II. Other significant conditions	contributing to death i	out not resulting in	the underly	ing ceuse giv	en in Part I.	23b. Die	d tobacco	usa cont	tributs to the c	suss of death?
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Ē							10	Yes 2	⊠No	1 🗆 Vac	2 No
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Be	25. Was cese referred to medical examiner?	Hospital:			7 DOA Oth	or.	eath (Check only				
10	10 Yes 2 No	1 L Inpati			J DOA	4 Li Norsing	Home 5 Res				
on:	27. Manner of Death  1   Natural 5 □ Pending	28a. Date of Inju (Month, Da	ay Year) 28b. 1	ime of njury	28c. Injur		28d. Describe	now inju	ry occurre	ia .	
iffication	2 ☐ Accident Investiget	ho		М		Yes 2 □ No					
=	3 ☐ Suicide 6 ☐ Could not determine	d 266. Place of in	jury - Al home, fa tc. (Specify)	rm, street, fa	ctory, office			(Street ar own, Stete		r or Rural Rou	te Number,
Certification:											
Ca.		Physician: To the best									Auca/s)
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Σ	29b. Signature and title of certifier	1 7/1	4/	2 L	29c. Licens				710	(Month, Day,	Year)
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	30. Neme end eddress of person wh	o completed square of	death (Item 22c)	Tune Drint							2.
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C	31. Date filed (Month, Day, Year)		rar's Signature	110						/	
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egistrar	- 1 Y	1000		· /	JULIU	W.					

DHMH 16 Ray 6/95

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### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	1. Decedent's Nam	ne (First, Middl	fie, Last)				Certifica	210 01	Dodin	2	. Date of Dea	th		3. Time of Death
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eral	5. Social Security	Number	6. Sex	· · · · · · · · · · · · · · · · · · ·	7. Age (in	yrs. last birt	thday) If Und Months	er 1 Year s Days	If Under 24 Hours	Hrs. 8	Date of Birth (Month, Day	Year)	9. Birth	nplace (State or Foreigntry)
ctor	161-09-9		1U M	2 🗓 F	82		Yrs.				1-09-1			OON, PA
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by Funeral Director	DELAWARE		SSEX			EWEY 1								1 ☑ Yes 2 □ N
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Funeral	11. Marital Status	71(1)1 111			edent Ever	in U,S.			lispenic Originan, Mexican,	? (Specif	y Yes or No-	_	. Race - Amer	
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			HES/ L	DAUGH		0b. Place of	TANGLE Disposition (N		CI.,		Date DELA		• 1995 ation - City or	
	JE Burial &	ELINOR W. HUGHES/ a. Method of Disposition  Burnal Community 3 Re Donning JOther (Seecity)			State	cemeter	ny, crematory of	r other pla			-13-99			D, DELAWAR
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State of Maryland / Department of Health and Mental Hygiene

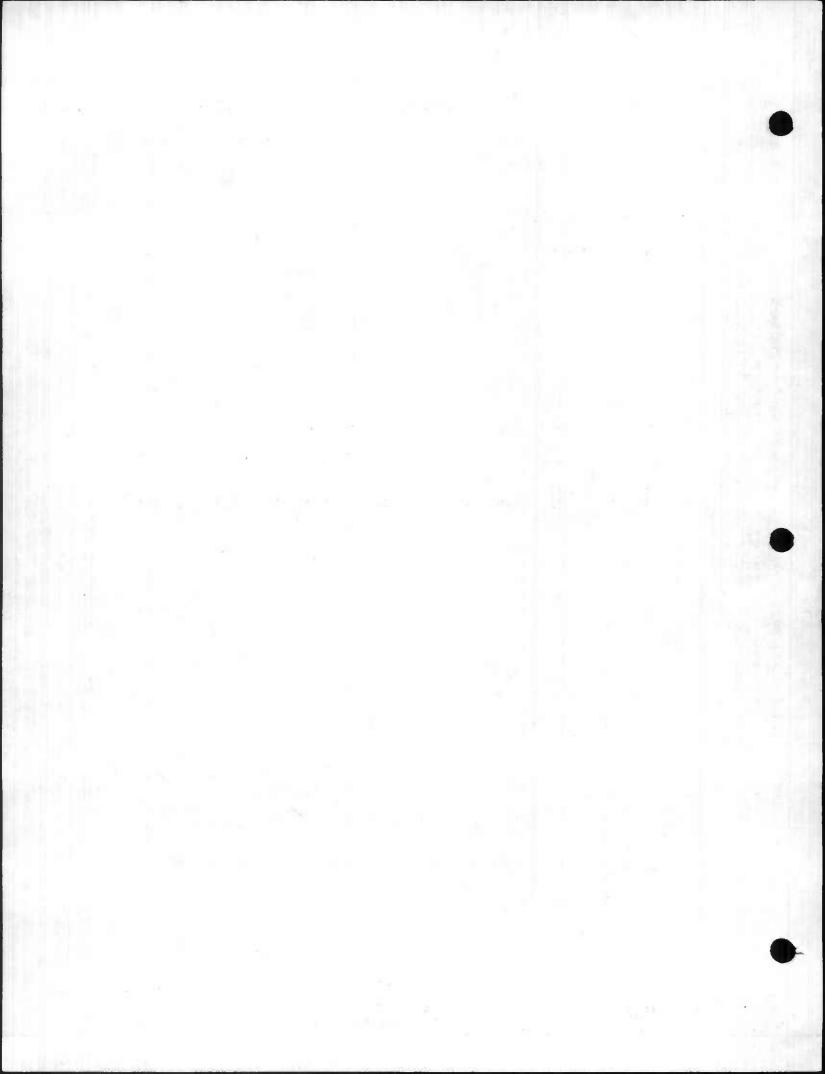
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T P E S	Nellie Fisher 20a. Method of Disposition	Daughter		322 Pond Circ Disposition (Name		bad	Midlothian Date	20c. Location -	City or To	21543-
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permit. Page Department of Important: if any Injury or pncs.	21. Signeture of Funerel Service Lice	i uni	1	22. Name and			rost Ave., F	rostbura.	MD 2	21532
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certificate rector, pag	25. Was case referred to medical					26. Place of Dea	th (Check only on	e)		
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or A Nine In by	4 Homicide determined	28e. Piece of Injury building, etc.		ii, street, tectory, t	MINCAS		City or Town	, Stete)	si oi nara	ii riobie rvailiber,
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To the Hospital or Attending within 24 hours after death.  To the Funeral Director: At completely filled in by the furnity Medical Certification	29e. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner of the cause (s) and manner of t								nner as si and due to	tated. o the cause(s)
Neithly Some	29b. Signature and little of certifier			29c. l		number	2	9d. Dete signed	(Month,	Day, Year)
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1 ((12)	10 Dr	Dox			(	70 32		may / /	,	
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mv	George M. Breza, I	v.D., 912 Seton	Drive, C	umberland,	, Mai	rylana 21:	DUZ SUC			
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Registrar	MAY 1 7 1999	Lanar	(1)	Span	la					

Herman William Winters Allegony Cumberland Sacred Heart Hospital 08 220-10-1567 24-Mar-19 Maryland Midlothian Maryland Allegany 20318 Pond Circle Road U.S.A. White owner/operator prining loop William H. Winters Elizabeth Luceile Barnes Daughler 20322 Pond Circle Road Midlothian Maryland 21543-Nellie Fisher Fostburg Menional Pasi 16-May-99 Frostburg, Maryland

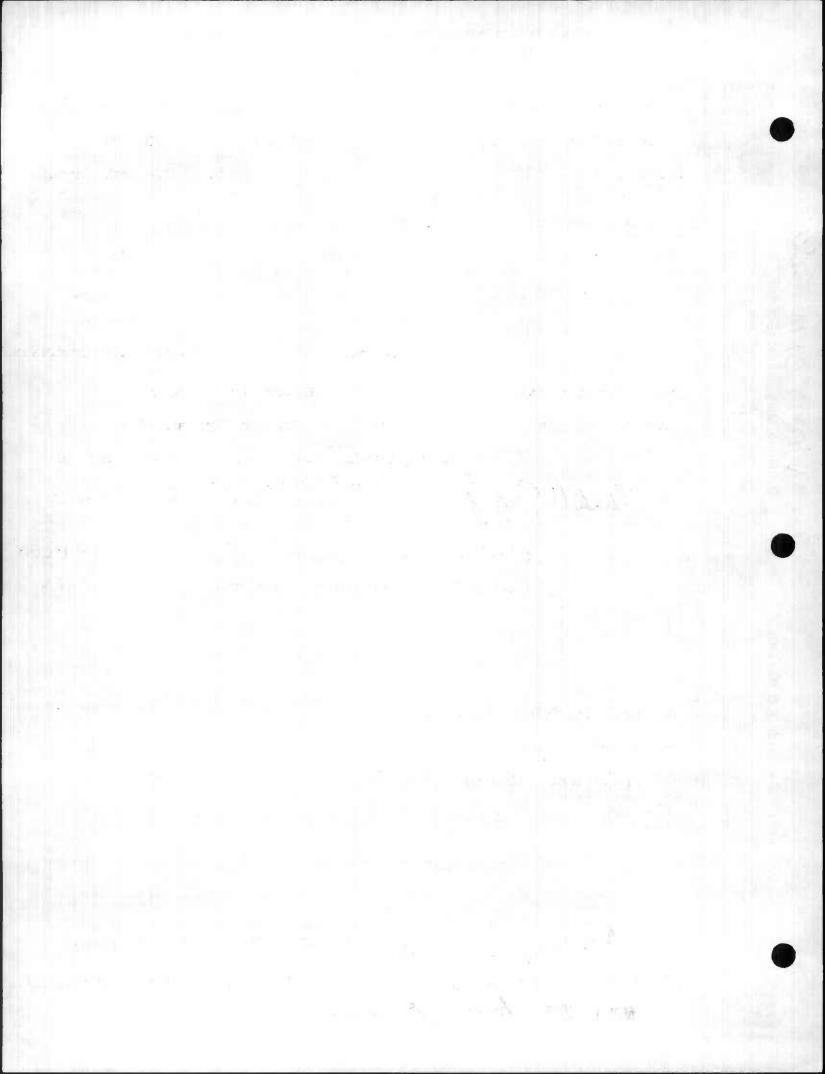
Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

State of Maryland / Department of Health and Mental Hygiene

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			State of Maryl		ertificate of			Reg. No.		7353
	Dhusisian	1. Decedant's Neme (First, Middle, La	st)			SHA	2. Dete of De Month	Day Day	Yeak	3. Tima of Death
	Physician /Medical	OLIN GEORGE	WOOD				MAY		1999	0535
	Examiner	4e Facility Neme (If not institution, giv	TOTAL CONTRACTOR			4b. City, Town, or I.				
( F	Gertage	FALLSTON GENERAL  5. Social Security Number 6. S		yrs. last birthda	(v) If Under 1 Yeer				FORD 9. Birtho	place (State or Foreign
	Funeral Director		XIM OF E	85 Yrs.	Months Deys	Hours Min.	8. Date of Bir (Month, De April 4	y, Year) 1, 1914	West	olece (Stete or Foreign ortry) Virginia
	yland	10a. State 10b. County	10c.	. City, Town or I	Location				1	10d. Inside City Limita
is	n the Marylan r 28a-f show Incurred at	Maryland Harfo	rd	Bel Ai	r					1X Yes 2 No
7	with the Ma t or 28s-f s be notified Director	10e. Street and Number			10f. Zip Code			10g. Citizen of		ntry?
17	ofter death very transfer them 234	808 Marcie Ct.	12. Wes Decedent Ever in	in II S 13	21014 Was Dacedeni of F	Hispanic Origin? (Sc	secify Yes or No		USA ce - Amaric	cen Indien.
M	VIZID-UUZU within 72 hours effer death with the Maryland ene. than 'natural', or items 23s or 28s-f show ha Madical Examiner must be notified at ompleted by Funeral Director	1 Never Married 2 Married	Armed Forcas? 1 ☐ Yes 22 No If Yas, Giva Yaar or Dates:		If Yes, specify Cub 1 ☐ Yes 2√2 No	en, Mexican, Puerto	Rican, atc.)		ck, White,	
3	Z1Z15-00Z0 d within 72 hours of gione. r than "natural", or the Medical Exam completed by I	15. Decedent's Ed	lucetion	16e. Dec	edent's Usuel Occup re kind of work done DO NOT use retire	pation	din a	16b. Kind of B	usiness/In	dustry
7	EZIZIS-U led within 72 ho ygiene. Ner than "natur. It, In Medical Completed	(Specify only highast green Elementery/Secondary (0-12)	College (1-4or 5+)			d) d)	ony			
		8 17. Fether's Neme (First, Middle, Last)		На	ndyman	18. Mother's Nem	a /First Middle			Improvemen
	yiand pould be filed I Mental Hyg marked other matic avent,					Livora			,,,,	
(A)	E 48 2 E E	James Harrison  19e. Informent's Name/Reletionship (		19b. Me	iling Address (Street		,	McClung	, State, Zip	Code)
0	e, Maithe Healthe em 27 is	Mary A. Wood/Wife			Marcie Ct	., Bel Ai				
50	altimore, mit. Peges 1 ar pertment of Hea portant: if Item; y Injury or other	20e. Method of Disposition  1 Duriel 2 Cremetion 3 D	Removel from State	cemetery, cr	position (Neme of emetory or other ple		Dete	20c. Location		
5	Galtim  permit. Peg Depertment Important: I any Injury o	4 Donetion 5 Other (Specify 21. Signature of Junear 2 rvice Licer		4-	Service C	1	-8-99	Towson		-
	DESILIMOTE, IN permit. Peges 1 and Department of Health Important: If item 27 any injury or other temp.	Nucleo A.	Smach.		22. Name and Addra Howard K. 50 W. Bro					A. Land 21014
		23a. Pert1. Enter the disease, or com shock, or heert feilure. List only	plications that caused the d one cause on each line.	deeth. Do not e	nter the mode of dyi	ng, such as cardiac	or raspiratory e	errest,	1	Approximete Interval Between Onset and Death
	Physician /Medical Examiner	Immediate Ceuse (Finel disaese or condition	CARDIDE	TENIC	SHO	CK				18 HOURS
	N CONTRACTOR OF THE PARTY OF TH	resulting In deeth)		to (or es a cons		Y DISE	ASE			VEADS
	executed in end inelations it	Convention les conditions	b. COLONA	to (or es a cons	ACIEC	7 12(30	NDE		i	YCALS
9	The Cords, P.O. Box 68/60,  The law requires that the death certificate be executed ate has been signed by the ettending physician end page 2 should be deteched for use as the buriel-transit completed by Physician/Medical Examir	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(0. 00 % 00.10						
	ficete be ex physician ex the buriel edical Ex	thet Initiated events resulting in deeth) Lest	C. Due to	o (or as a cons	equance of):					
	ox o certification of the same as the same		d							
	box of the seath certification of the use as included in its clan/Median of the seath of the sea	Pert II. Other signiffcent conditions of	and allowed and a second and a second	annulting last ha		una la Bod I	agh Did	toheses use es	an tulbusta 4	o the cause of death?
9	T.O. at the d by the deteched Physic	Pert II. Other significant conditions of	IN EX 1	resulting in the	underlying ceusa gr	ven in Pert I.	1.5531.0.1	Yes 2□ No	3 Pro	
	IS, F.O. BOX es that the death cert igned by the ettending be deteched for use by Physician/M	ACUTE MEN	AL TAIL	ULE						
	The law require the law require page 2 should I Completed I	HYPERTENSI	ON				24e. Wes	an eutopsy ormed?	av	/ere autopsy findings /ailable prior to ompletion of ceusa
	Hes b	00,110 = 15	1.6775	G.	10.				of	death?
			HEAR!	TAIL	JRE			Yes 2 No	1	☐ Yas 2☐ No
	ysician: ysician: is certific director,	25. Wes cese referred to medicel exeminer?  1 Yes 2 No	Hospital:	2 ER/Outpati	ent 3 DOA Ott	26. Place of Dea her: 4 □ Nursing H		one) Idence 6 □Oti	her (Speci	(fv)
	ding Phys.  After this funeral d	27. Menner of Deeth 1 Netural 5 □ Pending	28a. Dete of Injury (Month, Dey Yea	-	of 28c. Inju			how injury occu		,,
	SION O tending Ph leath. for: After thi the funeral	2 Accident Investigation 3 Suicide 6 Could not b	1		M 1	Yes 2□No				
	LIVISION OF VITAL RECORDS, ball or Attending Physician: The law requires the staffer death.  at Director: After this certificate hes been signed in by the funeral director, page 2 should be certification: To Be Completed by	4 Homicide determined	28e. Plece of Injury - A building, etc. (Sp		street, fectory, office		28f. Location (	(Street end Num wn, Stete)	ber or Run	al Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this carific, completely filled in by the funeral director, Medical Certification: To Be (	(Check only 2 Madical Exam	ysician: To the best of my ninar: On the basis of exam	knowledge, dee	ath occurred at the ti	me, dete and place opinion, deeth occur	end due to the	ceuse(s) end m	enner as s	stated. to the ceuse(s)
	o the lithin 2 or the lomple	29b. Signatura and Mila of certifier	end menner stated.		29c. Licens	sa number		29d. Data signe	ad (Month.	Day, Year)
	F3F8/	· MALOU	Man Pran	10	Da	357097		MAY Z	19	99
	h	30. Neme and eddress of person who	completed cause of deeth (	(Item 23e) (Type	e, Print)	- COX I		1-11-1	(11	
		VIJAY M. ABHY	ANKAR 2	NORT	HAVE	SUITE	101 BE	PLATR	MI	21014
	State Registrar	31. Dete filed (Month, Day, Year)	37 Registrar's S	igneture 6.	Spark	,				



State of Maryland / Department of Health and Mental Hygiene

**Funeral Director** 

**Physicia** /Medic Examine

must be n

Maryland 21215-0020

**Physician** /Medical Examiner

centificate has been signed by the attending physician and lirector, page 2 should be detached for use as the burial-transit

WIRSING Drildm

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours efter deeth.

To the Funeral Director: After this certific, completely filled in by the funeral director,

Medical Certification: To State Registrar

29a. Certifiar (Check only one)

29b. Signalun

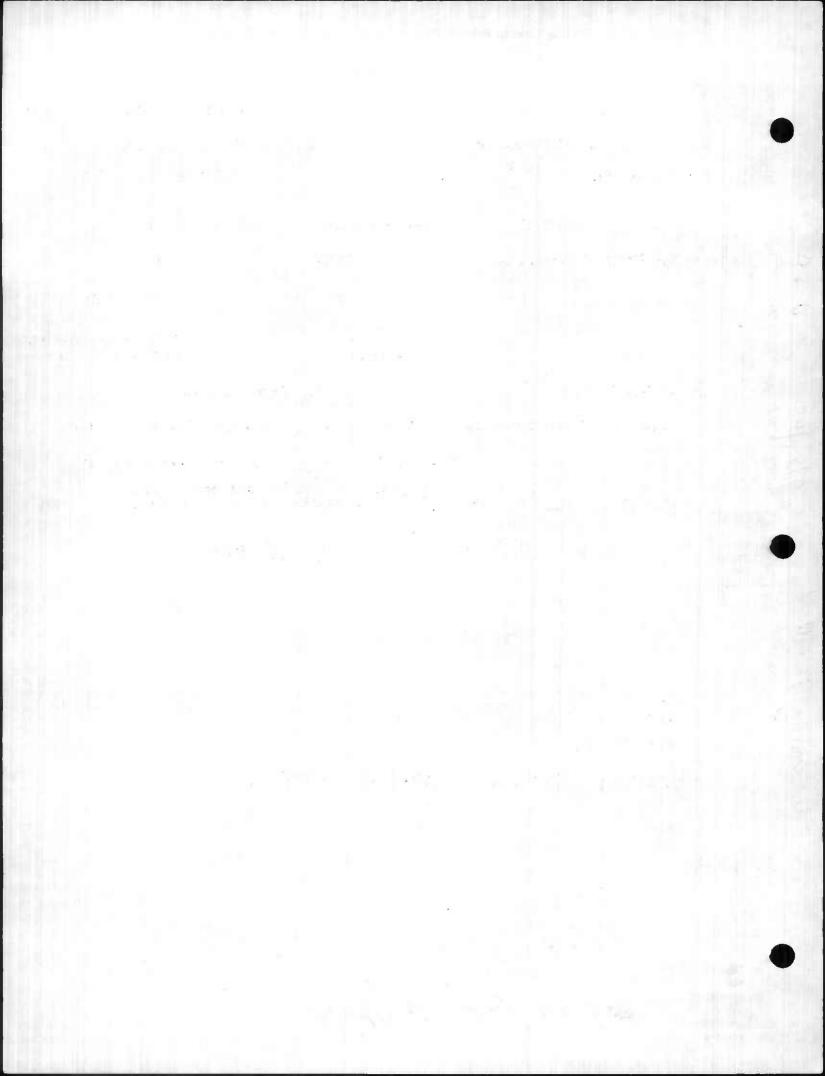
				Cei	rtificat	e of	Death			Reg.	No.	100	A. W. M. C.
1. Decedent's Nem	e (First, Midd	dle, Last)							2. Date of I		Day	Year	3. Time of Deeth
Mildred	Ann \	Wirsing							April		,	999	3:50am
4a Fecility Name (	lf not institution	on, give street and n	ımber)				4b. City, To	own, or L	ocation of De		4c. County	y of Death	
Harford	Memo	rial Hospi	tal				Havre	e de	Grace		Harfo	ord	
5. Social Security N	lumber	6. Sex 1 ☐ M 2 🗶 F	7. Age (In yrs. les		If Under Months	r 1 Year	If Under	24 Hrs. Min.	8. Date of I	Rirth			place (Stete or Foreign ntry)
213-28-7		ILM ZZ	68	Yrs.					05/25				MD
Usuai Residence o	10b. Count	h	10c. City, T	Town or Lo	cation								10d. Inside City Limits
													1 XYes 2 No
MD		arford	Ha	vre			1			1	min (	148 . 0	
10e. Street and Nu	mber				101. Zig	Code				10g.	Citizen of	What Cou	ntry/
	th Sto	kes Stree				2107					USA		
11. Maritel Status		Armed F	cedenf Ever in U,S. orces?	13.	Was Dece f Yes, spe	denf of locify Cub	Hispenic Or an, Mexice	igin? (Sp n, Puerto	ecify Yes or lo Rican, etc.)	No-		ce - Ameri ck, White,	cen Indian, , efc.
1 Never Marr		If Yes, G	2 <b>X</b> No ive		1 ☐ Yes	2 No	Specify:				Specif	v: WI	hite
3X Widowed													
(Spec	15. Decede	ent's Education lest grade completed	)	6a. Deced	denf's Usu <i>kind of wo</i> DO NOT u	ork done	durina mos	st of work	king			lusiness/Ir	
Elementary/Seco		Collega	(1-4or 5+)				<i>(a)</i>						Ordnance
12th		- ( A)		Sec	retar	<b>-y</b>	40 Math	ada Nam	na (First, Midd	-			d School
17. Father's Name												ne)	
William	-								M. F				
19a. informant's N									ral Route Nur.				
		cci- Daug					St.	Ha	vre de				
20a. Method of Dis		3 □Removel from	0.0.00	e of Dispo			ice)	į	Dete	20c	. Location	- City or T	own, State
4 Donation				utia	Ceme	eter	У	5	/4/99	Pe	rrym	an, I	D
21. Signature of Fu	ineral Service	e Licensee	· .				ess of Facili		1 . 1		D 4		
- XL	0	e Mi	mul	712	3 C	Mai	nith r	tone	ral Ho Havre	me,	Cra.		MD 21078
23a Page Enter t	ha disease, d	or complications that st only one ceuse on	ceused the death.	Do not ent	er the mod	de of dy	ing, such as	cardiac	or respiratory	errest,	Ora	ce, n	Approximete
sheck, or hea	irt failure. Lis	st only one cause on	eech line.									1	interval Between Onset and Death
Immediata Causa		Men	Whom (	m/1	h cont	1 6	W/ (	mi	HARDDE	20/			
disease or condition resulting in death)	n	a. 1110   F	allello o	MINNI	W Ink	0	The d	1148	I'M IC PAC	11/		- 1	
			Dua to (or a	s a consac	quence of)	:	1					1	
		b										1	
Sequentially list co	nditions, nmadiata		Due to (or as	s a consec	(uence of)							1	
cause. Enfar Unde Causa (Disaasa or	injury 1	С							.,			1	
that initiated evants resulting in death)	Last		Due to (or as	s e conseq	uence of):								
		d											
Part II. Other signif	icant condit	tions contributing to	leath but not resulting	ng In the u	nderlying	ceuse g	ven in Part	l.	23b. D	d tobac	co uee co	ontribute 1	to the cause of death'
CAMDONALL	61/3/11	when Oi	Mmmh	nien	174				1	☐ Yee	2□ No	3 □ Pro	bably 42 Unknow
A LA	1		0	13,000	1.4				P.4-111		414	7 94h 14	Vara autonou findin-
WIBL	1 1/1	wison								as an a		a	Vere autopsy findings vailable prior to ompletion of cause
. 1	200		,	. la	~	-	0 /	-	,				death?
the four	OV	Menhaus	Mx 51h	MY	4661	0	Migh	A WA	- 11	Yes	2 🗆 No	1	☐ Yes 2☐ No
25. Was case ofer	red to medic		/ 1	1			26 Plac	e of Dea	h (Check on	ly ona)			

completion of cause of death? En Meron 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case 26. Place of Death (Check only ona) Other: 2 No Inpatient 2 ☐ ER/Outpetient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mar for of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation Natural 1 Yas 2 Accident 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

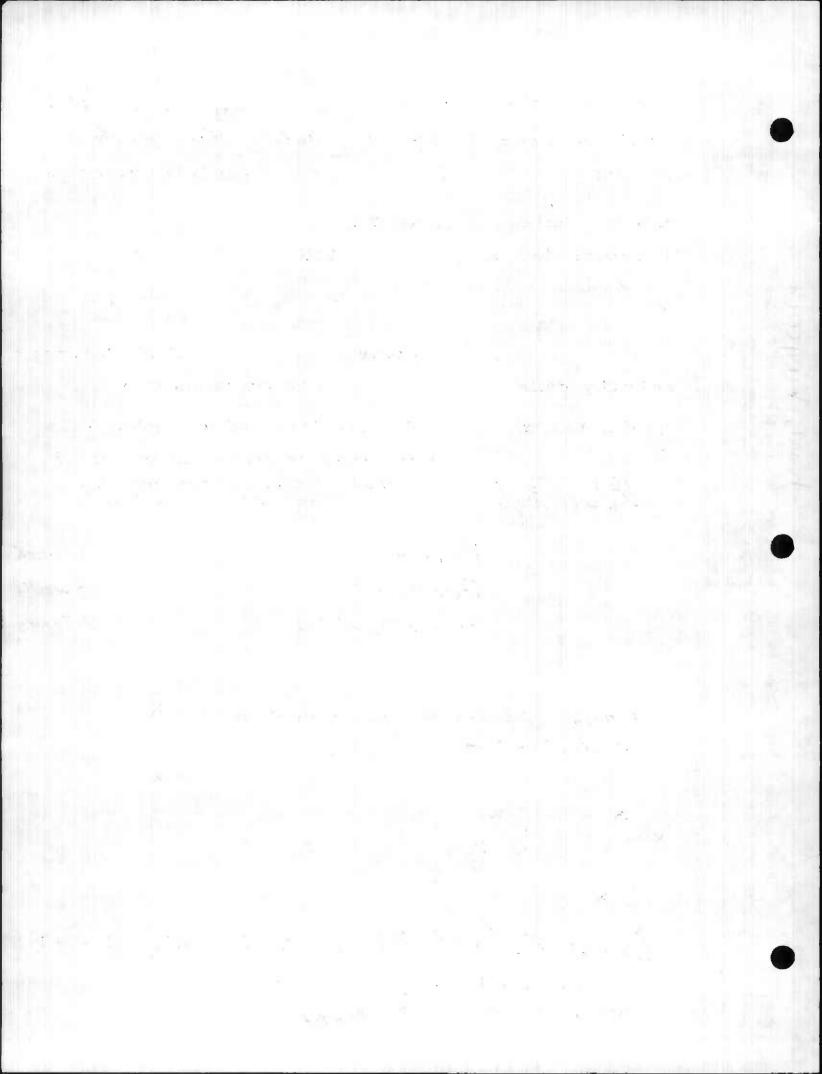
1 Certifying Phyelcian: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, end due to the ceuse(s) and manner stated.

d (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene

		Ce	ertificate of	Death	Reg.	No.	1000	
Physician	1. Decedent's Name (First, Middle, Last)	Wood	(		2. Date of Death Month	Day Year 13 1999	3. Time of Death	
/Medical Examiner		Hospit		4b. City, Town, or Local Fallston		4c. County of Deat		
Funeral Director	217-07-2499 1 M 228F	n yrs. last birthday 88 Yrs.	/) If Under 1 Yeer Months Deys	If Under 24 Hrs. Hours Min.	Date of Birth (Month, Day, Ye une 5, 1	9. Birt 910 N. C	hplace (State or Foreig untry) Carolina	
filed within 72 hours after death with the Maryland Hygiene.  Hygi	10a. State 10b. County 10							
	10e. Street and Number  1708 Landmark Drive, Apt. H	rolest	10f. Zip Code	050	10g.	Citizen of Whet Co	untry?	
	3 ₩idowed 4 Divorced If Yes, Give Yeer or Dates:	r in U,S. 13.	n U.S. 13. Was Decedent of Hispenic Origin? (Specify Yes, specify Cuban, Mexican, Puerto R  1 □ Yes 2 No Specify:			fy Yes or No- can, etc.)  14. Race - American India Black, White, etc.  Specify: White		
be filed within 72 hours tal Hygiene. d other than "natural", event, tra Medical Exe Be Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	(Give	edent's Usual Occup e kind of work done DO NOT use retired	etion during most of working d)	7	16b. Kind of Business/Industry  Clothing Manufacture		
d be filed antal Hygical colors of the colors of the colors of the Color	17. Father's Name (First, Middle, Last) Charles Clay McMillan, Sr.	Seam	BCLE33	den Sumeme) Garvey				
should and Men market umatic	19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ling Address (Street	end Number or Rural			Zip Code)	
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, the Magante.	Raymond C. Wood/ Son  20a. Method of Disposition  Disposition  Removal from State  Donation 5 Other (Specify)	cemetery, cre	position (Name of Place)  The Memorial Gardens 5-17-99  Date					
pemit. Departm Importar any inju	21. Signature of Funeral Service Licensee	l Home, I	P.A.					
Attanding Physician: The law requires that the death certificate be executed many redent.  If death, the tuneral director, page 2 should be datached for use as the burial-transit per page 2 should be datached for use as the burial-transit per page 1 should be datached for use as the burial-transit per page 1 per page	23a. Part 1. Enter the disease, or complications that caused the abook, or heart failure. List only one disease on each line.  Immediate Ceuse (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest		Approximate Intervel Between Onset end Death One was 3 week Unknow					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute to the ca							
Tha law requiras th cate has been signed page 2 should be d	Malnutrition 24a. Was an autopsy performed?						Were autopsy finding available prior to completion of cause of death?	
Tha Is					1□ Yes	2 No	1 ☐ Yes 2 ☐ No	
Partie of	25. Was case referred to medical examiner?  1   Yes   2   No							
To the Hospital within 24 hours a To the Funeral I completely filled	29e. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as atated.  Check only one)  Check only one)							
Toth Toth comp	29b. Signature and title of certifier Many	rhen M.	29c. Licens	0707		Date signed (Mont	h, Day, Year)	
10	30. Name and address of person who completed cause of death  31. Dete filed (Month, Dey, Year)  32. Begistrar's	Lang	o, Print) phear	M.D.				
State Registrar	MAY 1 4 1999	~ 4	lan -					



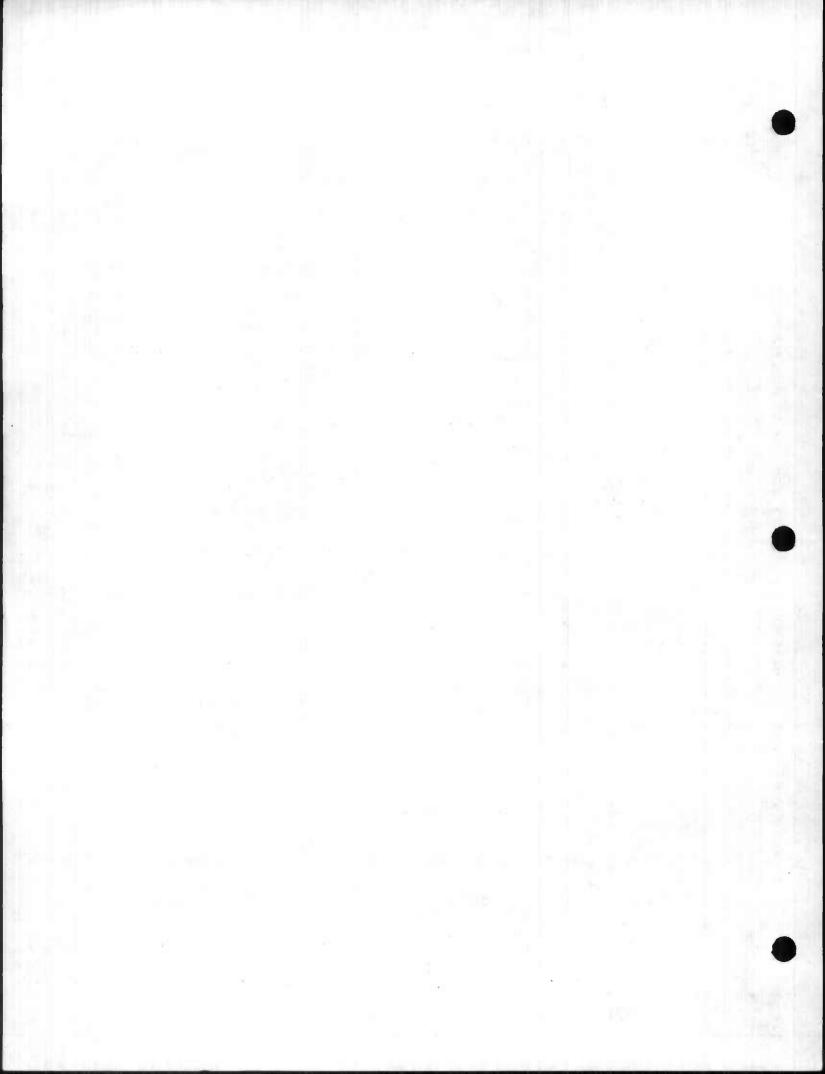
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death IRENE BELLE YOUNG **Physician** 3, 1999 4c. County of Death /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) Examiner CARROLL COUNTY GENERALHOSPITAL WESTMINSTER CARROLL If Under 1 Year 8. Deta of Birth (Month, Day, Year) 6/21/1929 5. Social Security Number 7. Aga (In yrs. last birthday) If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🖸 F 69 220-26-0266 Director MARYLAND Usuel Rasidance of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director MD. CARROLL WESTMINSTER 288-1 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 8 310 CHURCH COURT 21157 USA. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, apecify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Evar in U,S. Armed Forces? 14. Race - American Indian, Black, Whita, atc. 1 ☐ Yes 2 ☑ No 1 Nevar Married 2 Married b altimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 **POSTMISTRESS** COLLEGE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 88 Pages 1 and 2 should be and Mental Is marked RAYMOND LEWIS YOUNG JESSE BELLE STARNER 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21787 19a, Informant's Name/Ralationship (Type, Print) Health EDNA Y. EYLER SISTER 4512 FRANCIS SCOTT KEY HIGHWAY, TANEYTOWN, MD mportant: If Item 27 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burlel 2 Cremetion 3 Removal from Stata 4 Donation 5 Othar (Specify) KRIDER'S CEMETERY 5/16/99 WESTMINSTER, MD. 22. Nama and Address of Facility FLETCHER FUNERAL HOME 21. Signature of Eunarai Sarvice Licensee 254 E. MAIN ST., WESTMINSTER, MD.21157 23a. Part 1. Enfar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hadar failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immedieta Cause (Final disease or condition rasulting in daath) /Medical PANS Examiner Sequentially list conditions, if any, laading to immadiate causa. Entar Undarlying Ceuse (Diseese or injury that initieted events resulting in death) Last Physician/Medical Dua to (or as a consequence of) Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deglif? 1 Yes 2 No 3 Probably 4 Onknown þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yas 2 ☐ No 1 Yas 2 No Attending Physician: 25. Was case referred to medical axaminar? 8 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 1.2 Inpatient edical Certification: To 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Menner of Death 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural
2 Accidant 5 Panding Invastigation 1 Yes 2 No 3 Suicide 6 Could not be datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, atc. (Specify) 4 Homicida 6 To the Hospital
within 24 hours a
To the Funeral C
completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner atated. 29a. Certifier 29b. Signature and titla of certifier 29d. Data signed (Month, Day, Year) 29c. License number Nama and address of person who completed cause of death (flem 23a) (Type, Print) 200 Memo, PINT ANOLL COUNTY 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State MAY 17 1999

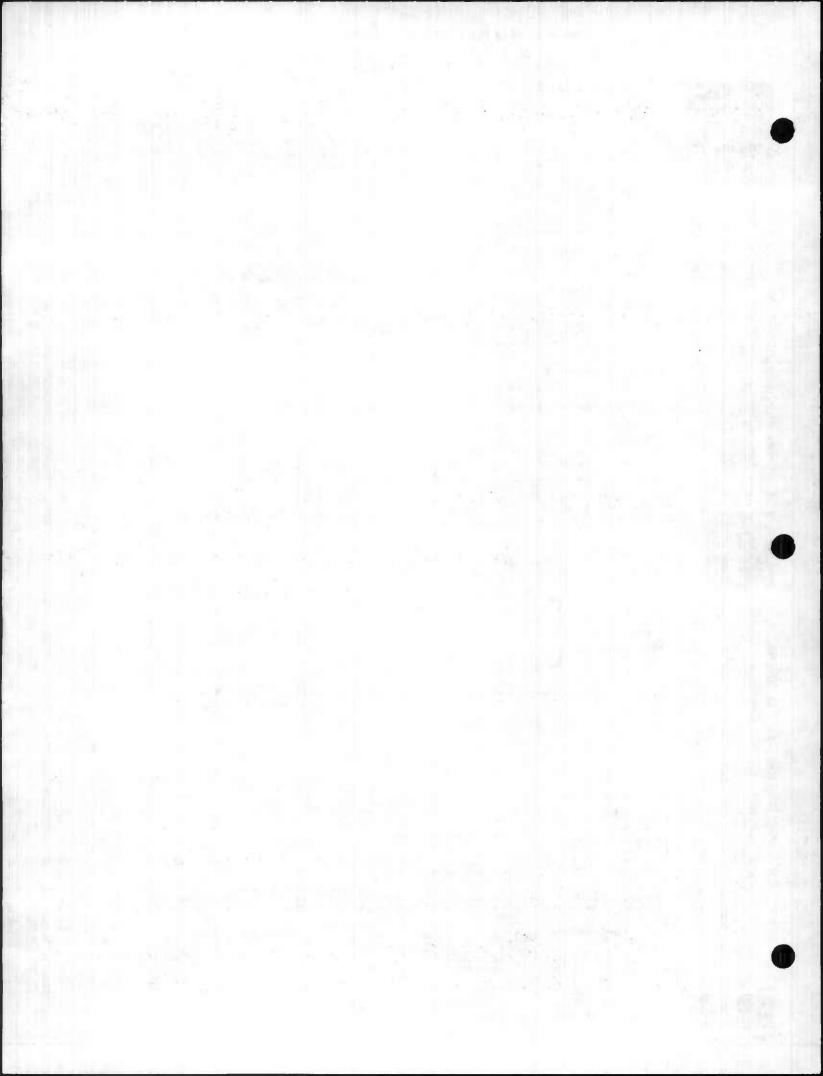
**DHMH 16 Rev 6/95** 

Registrar



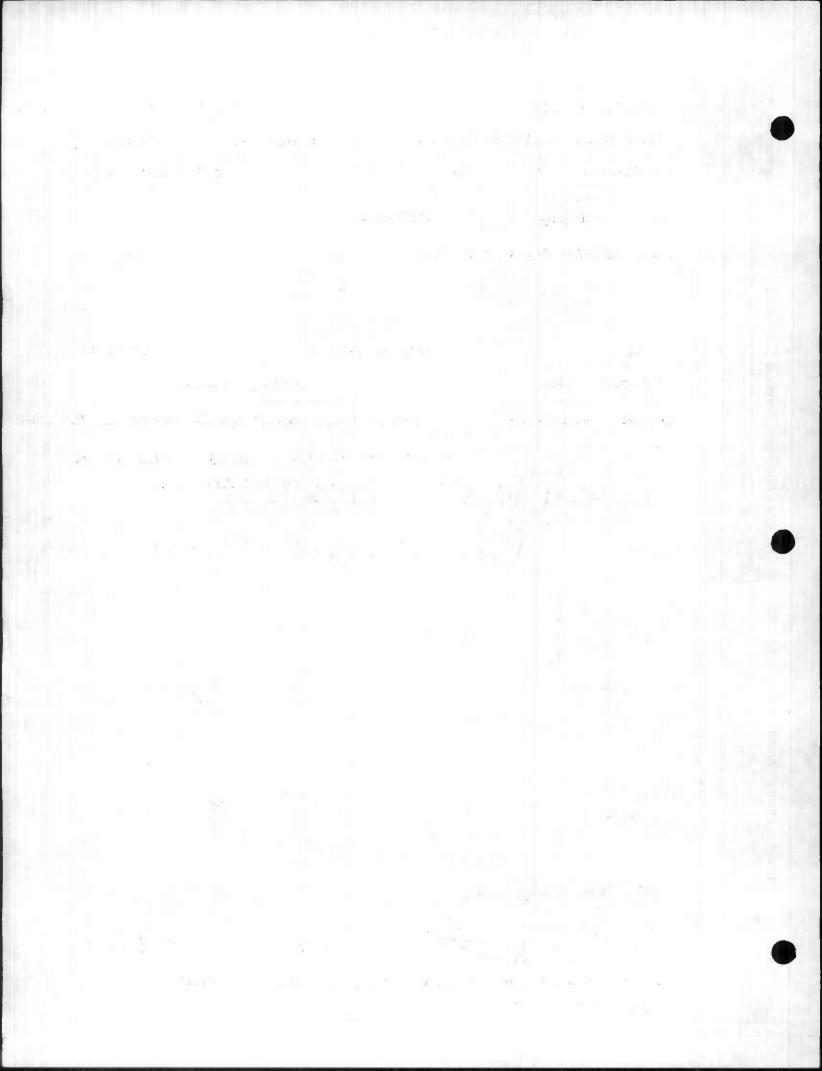
State of Maryland / Department of Health and Mental Hygiene

		otato of Marylan		te of Death	R	eg. No.	173			
Physician /Medical	1. Decedent's Name (First, Middle, Last,	ee Yost			2. Date of Deat Month 05	Day 12	99 13	ime of Death		
Examiner	4a Facility Name (If not institution, give 3038 Richards (		C	Fort Me	Location of Death	4c. County		Arundel		
Funeral Director	22. 00 00	7. Age (In yrs.	Month	er 1 Year If Under 24 Hrs s Days Hours Min		Year) 1967	9. Birthplace (S	itate or Foreign		
hend wo	Usual Residence of Decedent  10e. Stete 10b. County	Usual Residence of Decedent  10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits								
Serfer Serfer		Arundel		1 Ves 2□No						
offer death with the Meryland offer must be notified at Funeral Director	3038 Richards (			20755		0g. Citizen of W				
Full Full	11. Merital Statua  1 Never Married Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		edent of Hispanic Origin? (secify Cuban, Mexican, Puer 2 No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: white				
72 72 ete	15. Decedent's Edu (Specify only highest grad Elementery/Secondary (0-12)	15. Decedent's Education Specify only highest grade completed) Secondary (0-12)  College (1-4or 5+)  Countant				during most of working				
re, Maryland 2121 s 1 end 2 should be filed within Health and Mental Hygiene, tem 271s marked other than other traumatic event, the Me To Be Compi	17. Father's Neme (First, Middle, Last) Robert C. Wade	18. Mother's Na Mary	or's Name (First, Middle, Maiden Surname) (Kamauf)							
Mary 12 sho h and h r is me traume	19a. Informant's Name/Relationship (T) Robert J. Yost	rpe, Print)	19b. Malling Addres 3038 Ric	ss (Street and Number or Fi chards Cour	dural Route Number	, City or Town, Meade	State, Zip Code) MD 2	20755		
0 0 0	husband 20a. Method of Disposition 1 Burial 2 Cremation 3 F	Removal from State	Plece of Disposition (A emetery, crematory o	r other place)			Location - City or Town, State			
Baltimore, permit. Peges 1 er Department of Hea important: if Nean; any Injury or other	4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Signature of Funeral Service Licensee  23. Cumberland, Maryland 21502									
Physician	23a. Part1. Enter the disease, or computations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate interval Between Onset and Death									
/Medical Examiner	Immediate Cause (Final disease or condition resulting In death)  a. Metastatic Colon Cascinema 8 mos.  Due to (or as e consequence of):  Colon Cascinema 23 mos.									
ansit		D		in Carcin	920 C		123	smos.		
68760, ficate be executed physician and is the buriel-trensit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initileted events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):									
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deeth cer deeth cer e ettendin ed for use	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute to the cause of the ca									
Is, P.O. BOX es that the deeth cent igned by the ettendin be deteched for use by Physician/N			1□ Y	2 No	3 Probably	4 Unknown				
requir				24a. Was an autopsy performed? 24b. Were autopsy available prior to completion of death.		prior to				
= F # 2 0					1 🗆 Y	es 2/2 No	1 □ Yes	2 No		
/ita	25. Was case referred to medical examiner?	Hospital:		Other:	eath (Check only or					
Phys ald a digital distriction of the state	1 ☐ Yes 2 ☐ No  27. Menner of Death	28a. Date of Injury	ER/Outpatient 3□ 28b. Time of	28c. Injury at	Home 5 Resid			11000		
Division of To the Hospital or Attending P within 24 hours after death. To the Funeral Director: Affert completely filled in by the funeral Medical Certification:	Shatural   5   Pending   Investigation   3   Suicide   4   Homicide   Homicide   Suicide   Sui	(Month, Day Year)  28e. Place of Injury - At h-building, etc. (Specific	Work? 1 □ Yes 2 □ No ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, Stele)						
24 hours 24 hours Funeral etely filled dical C		elcian: To the best of my kno ner: On the basis of examine and manner stated.						euse(s)		
To the within To the comple	29b. Signature and Little of certifier  29c. License number  29d. Date signed (Month, Day, Year)									
8	Gund Dolawy D31551 May 13,199							177		
mes	30 Mame and address of person who co	completed cause of death (Item	n 23e) (Type, Print)	Hickory 5	170607 1	HenBlen	ntod 2	1061		
State	31. Date filed (Month, Day, Year)	32. Registrer's Signa	iture				))			



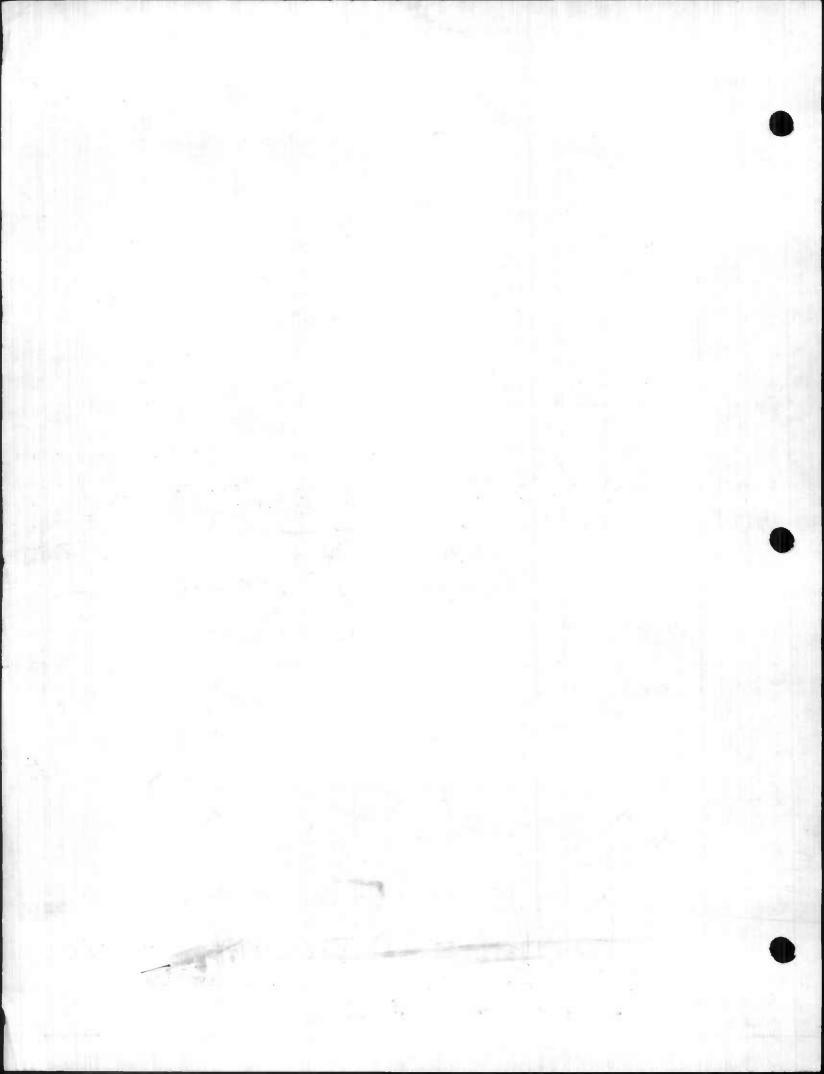
State of Maryland / Department of Health and Mental Hygiene

Physician	1. Decedent's Name (First, Middle, Last)						2. Date of Dee		/= 0	3. Time of Deeth
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/Medical Examiner			re street end number)			4b. City, Town, or Lo		4c. County of	Death	
	15821	McMullen	Highway SV	Apt C-3		Cumberlar	nd	Allega	anv	
Funeral	5. Sociel Security N	Number 6. S	Sex 7. Age	(In yrs. lest birthday)	If Under 1 Year Months Days		8. Dete of Birtl (Month, De)			ace (Stete or Foreign
Director	705-10-	-0120	120 M 2□ F {	30 Yrs.	Months Days	Tiours Will.	Jan 3		WV	
pe s	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location								10	d. Inside City Limits
Mery teth	MD	MD Allegany Cumberland					1 □ Yes 21⁄X			
Tec rec	10e. Street end Number 10f. Zip Code							10g. Citizen of Wh	at Count	ry?
ifier death with the Mer r flems 23a or 28a-f el niner mult be notified Funeral Director	15821 McMullen Hwy SW Apt. C-3 21502							USA		
me 2	11. Maritel Sletus		12. Wes Decedent B			Hispanic Origin? (Spean, Mexican, Puerto	ecity Yes or No-			
naturef, or items 23s or 28s-f show soles! Examined must be nottled at leted by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced		Armed Forces?  1 ☐ Yes 2	Yes 2℃ No specify:			Rican, etc.)	Biack, Specify:	White, e	hite
2 hou		15. Decedent's E	ducation	16e. Dece	edent's Usual Occu	pation		16b. Kind of Busi		
c ' # -	15. Decedent's Education (Specify only highest grede completed)  Elementery/Secondary (0-12)  College (1-4or 5+)						ing			
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TIES 0	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle)					e (First, Middle,	e, Maiden Sumeme)			
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d 2 should in end Men T fe market treumatic	19e. Informant's N	Name/Relationship (	Type, Print)	19b. Mail	ing Address (Stree	t end Number or Run	r or Rural Route Number, City or Town, Stete, Zip Code)			
rtt t	Louise	G. Zirk	-wife	1582	1 McMulle	en Hwy SW	Apt C3;	Cumberl	and,	MD 21502
40 40 0	20a. Method of Dis			20b. Place of Disp			Date	20c. Location - C		
Peges nert of mr. If its		Cremation 3 ☐ 5 ☐ Other (Specif	Removal from State	11.00	lemorial 1		05/19	Cumberl	and	MD
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Depa Impo	Scarpelli Funeral Home, P.A.									
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## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		State of Maryla	Certifica			F	eg. No.	17.39	50	
Physician	1. Decedent's Nama (First, Middle, Last)  1. OUT C CUDICTIAN 71.I.CV CD				2. Date of Dea Month	15 <sup>ay</sup> 1999	3. Time of 1:59			
/Medical	LUUIS UNKISTIAN ZWICK, SK.				May ocation of Death			Ari		
Examiner	29697 Vincent C	Martin Control of the			Mechanic					
Funeral Director	5. Social Security Number 6. Sec. 215 – 28 – 9963		( last birthday) If Und Month	ler 1 Year s Days	If Under 24 Hrs. Hours Min.	8. Data of Birth (Month, Day July 17		Birthplace (State Couptry) ry land	or Foreign	
2 *	Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Location			10d Insi			City Limits	
the Maryti 28e-f sho notified at									2X) No	
0 M O							Og. Citizen of What			
020 urs after death v aft, or thems 23s Examiner must by Furneral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	DED	TE 163 ZIGITO Specify.				American Indian, White, etc. White			
Maryland 21215-0020 at 2 should be flied within 72 hours at at 2 should be flied within 72 hours at the and Mental Hygisine. 'natural', or traumetic event, the Medical Exam To Be Completed by 8	15. Decedent's Education (Specify only highest grade completed)   16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)   12   12   13   14   15   15   16   16   16   16   16   16					king	16b. Kind of Busine			
d 2 d 2	17. Father's Name (First, Middle, Last)	12 Chief 7. Father's Name (First, Middle, Last) 18. Mother's 1						Y		
lance the till the ti	Louis Christian	Zwick				Marie Schreiber				
Shou shou wind M. I man I	19a. Informant's Name/Relationship (Ty		19b. Mailing Addre	ss (Street			r, City or Town, Sta	te, Zip Code)		
- C 2 24 F	Patricia R. Zwick/	Wife	29697 Vi	ncent	t Circle,	Mechani	csville,	Md 206	59	
Baltimore, somit. Pages 1 s Separtment of His mportant if Ilsan mortant if Ilsan myortant if Ilsan myo	20a. Method of Disposition  1 XX ourie 2 Cremation 3 CR 4 Donation 5 Other (Specify)	lamental from State	Place of Disposition (A commetery, crematory of Yland Vete	r othar pla		Date / 21,199	20c. Location - City 9 Chelten		ryland	
Balt permit memy injection	21. Signature of unotal Section in the following state of the death of the following shock, or heart failure. List only one cause on each line.  22. Name and Address of Facility The Huntt Funeral Home, Inc. P.O. Box 156, Waldorf, Maryland 20604  23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  24. Name and Address of Facility The Huntt Funeral Home, Inc. P.O. Box 156, Waldorf, Maryland 20604  25a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  25a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.									
Box 68760, eath certificate be executed attending physician and for use as the burial-transit clar/Medical Examiner	23a. Part / Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition rasulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or Injury that initiated events resulting in death) Last	Due to to	or as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of a consequence	lox	Pan Such as cardiac	ONEA	est,	Approxima interval Be	tween	
O. Bo. Be death the attenthed for unaffer ysiciar	Part II. Other significant conditions con	23b. Did t	obacco use contrib	oute to the cause	of death?					
Photography detay							'es 2□No 3[	Probably 4	Unknown	
Record ne law requir s has been sige 2 should			-			24a. Was a perfor	med?	4b. Wara autopsy availabla prior complation of of death?	to	
Vital I siclen: The certificate irector, pag o Be Co	25. Was casa refarred to medical examiner?				26. Place of Dea	Ih (Check only or	19)			
T the sign of T	1 ☐ Yes ZHNo		ing Home 5 Desidence 6 □Other (Specify)							
Division of Attending P as or Attending P as after death.  at Director: After tied in by the funers Certification:	27. Manner of Death  1 Natural  5 Pending  aveatigation	28a. Data of Injury (Month, Day Year)  28b. Time of Injury  Mork?  1 Yes 2 No								
Division To the Hospital or Attending I within 24 hours after death To the Funeral Director: After completely filled in by the funer Medical Certification	3 Suicide 4 Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, Stata)									
To the Hospital within 24 hours To the Funeral completely filled Medical C	(Check only 2 Medical Examin	To the best of my kn	owledge, death occurre ation and/or investigati	ed at the tir	ma, data and place, opinion, daath occur	and dua to the or red at the time, or	ause(s) and manne lata and place, and	er as stated. dua to tha cause(	s)	
ithin of the complex Mec	29b. Signature and title of certifier 29c. Licensa number 29d. Date signed (Month, Day, Year)									
F 3 F 8	DE BUOEAD DO6419 5-15-99									
	30. Name and address of person who co	applied cause of death (Ite	m 23a) (Type, Print) LEONALO	Hou	w, Me	1 200	50			
State Registrar	31. Date filed (North, Day, Year)	32. Registrar's Sign		loa	41					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O Certificate of Death Date of Death 1. Decedent's Name (First, Middle, Last) Physician /Medical 4b. City, Town, or Location of Deat 4a Facility Name (If not Institution, give street and number 4c. County of **Examiner** 47 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Months Days OYrs. Director Usual Residence of Decedent the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside Çity Limits item 27 is marked other than "naturel", or itema 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No CTIMORE Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 20 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Yeer or Detes: Black, White, etc.

Specify: AFRICAN filed within 72 hours after 1 □ Never Married 2 □ Married 1□ Yes 2□No Maryland 21215-0020 Specify: by AMERICAN 3 Widowed 4 □ Divorced Completed 16a. Dacedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiane. Important: If frem 27 is marked other than any Injury or other traumatic event. If a Merican Injury or other traumatic event. Elamentary/Secondary (0-12) Collega (1-4or 5+) 01 (First, Middle, Maiden Surname) 17. Father's Nama (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Streat and Number or Rural Route Number, City or Town, State, Zip Code) ADAMS BALTIMOREM021229 Lionel Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date ₩ Burial 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses BALTIMORE MO2120
Approximate interval Batween Onset and Death Part. Enter the disease or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not anter the mode of dying, such es cardiac or respiratory arrest **Physician** Immediata Causa (Final diseese or condition rasulting in daath) /Medical Examiner Examiner Due to (or as e consequance of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Causa (Disaasa or injury Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): 3 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 3 □ Probably 4 □ Whknown 1 ☐ Yes 2 ☐ No à þ 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of deeth? page 2 20 No 1 Yas 1 ☐ Yes 2 No 25. Was casa rafarred to medical examiner? Be 26. Place of Daath (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Panding investigation 1 Yes 2 No 2 Accident after deatl Director: 6 Could not be determined 28a. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 4 ☐ Homlcide 8 To the Hospital o within 24 hours at To the Funeral Di edicai 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture end title of cartifier 29c. License number D 47683 128/99 Mille 30. Name and address of person who complated causa of death (Item 23a) (Type, Print)

State Registrar Raymond Miller

31. Date filed (Month, Day, Year)

25

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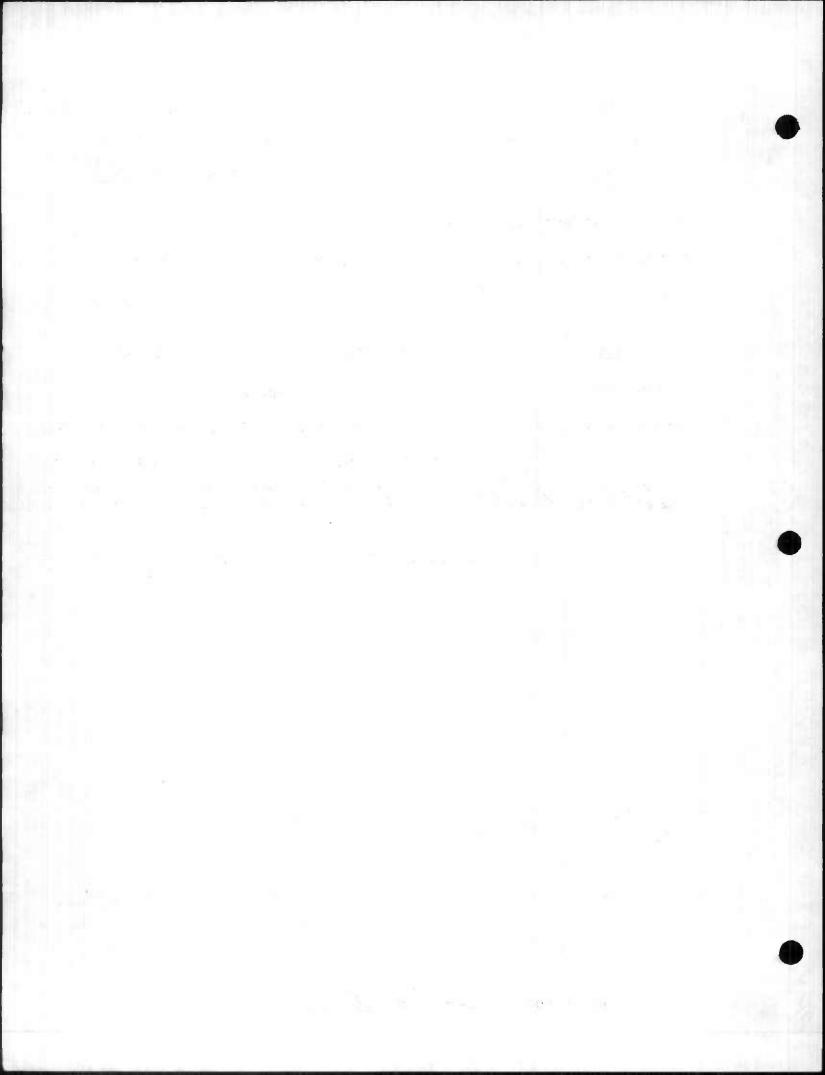
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32. Ragistrar'a Signature

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# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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A Facility Name of Process Analysis of Process Hill  Social Security Number  Social Security Number  Social Security Number  100 County  1			Sallie Lue Alston						Month	Day	Year	1:40 P.N
Martiner Health of Forest Hill  Martiner Health of Forest Hill  South Security Number  1			4a. Facility Name (If not institution,	give street end number)			4b.	City, Town, or L	-	T		1.40 1.1
217—38—2089   100 County Tool State and Number   10			Mariner Health	of Forest	Hill			Forest	Hill			
217-38-2089 10. County	Director			6. Sex 7. Age								State or Fore
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226 Part Entre the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, approximate interval Between Content and the disease or conditions. Immediate Cause (Finel disease or condition resulting in death)	de la como		boule	1 2		Willi	am C.	. Brown	n Comm	unity	F/H Ha	arford
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29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Dete signed (Month, Day, Year)  30. Name end eddress of person who completed ceuse of death (Item 23e) (Type, Print)	is certificete has been signed by the ettending director, page 2 should be detached for use e	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Last  Part II. Other significant condition  25. Was case referred to medical examiner?  1  Yes  No	b	Due to (or as a  Due to (or as a  It not resulting	e consequenca of):  a consequence of):  g in the underlying of	cause given	6. Plece of Deel	24a. Was perfo	Yes 2 No an autopsy mmed?  Yes 2 No one)  denca 6 □Ott	ontribute to the 3 Probabl  24b. Were a eveilet comple of deel 1 Ye	e cause of dea
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Dete signed (Month, Day, Year)  30. Name end eddress of person who completed ceuse of death (Item 23e) (Type, Print)	leath.  or: After this certificete has been signed by the ettending tor: After this certificeter, pege 2 should be detached for use e	To Be Completed by Physician/Medical	resulting In death)  Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last  Part II. Other significant condition  25. Was case referred to medical examiner?  1 Yes 2 No  27. Menner of Death 1 Netural 5 Pending Investiga 3 Suicide 6 Could no	b	Due to (or as a  Due to (or as a  it not resulting  int 2□ ER/O  y Year) 28b.	e consequence of):  a consequence of):  g in the underlying of  Dutpatient 3 DC  Time of Injury M	20A Other: 28c. Injury et Work?	6. Plece of Deel	24a. Was perfo	Yes 2 No an autopsymmed? Yes 2 No one) denca 6 Ott now injury occu	pontribute to the 3 Probable comple of deel 1 Ye	e cause of dealing autopsy finding autopsy fin
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Davel 5. Du D 32297 May 25, 1593  30. Name end eddress of person who completed ceuse of death (Item 23e) (Type, Print)	the prints of the death.  Funeral Director: After this certificate has been signed by the ettending tely filled in by the funeral director, page 2 should be detached for use as	Certification: To Be Completed by Physician/Medical	resulting In death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Ceuse (Disease or Injury that initieted events resulting in death) Last  Part II. Other significant condition  25. Was case referred to medical examiner? 1   Yes   2   No  27. Menner of Death 1   Netural   5   Pending   Investiga   2   Accident   3   Suicide   6   Could no determin  29a. Certifier   1   Certifying   Check only   2   Medical Eximals   Certifying   Check only   2   Medical Eximals   Certifying   Check only   2   Medical Eximals   Certifying	Hospital: 1 Inpatier  28e. Dete of Injun (Month, Dey tion to be ed 28e. Place of Injun building, etc.)  Physician: To the best of taminer: On the basis of taminer: On the basis of taminer:	Due to (or as a Due to (or as	e consequenca of):  a consequence of):  g in the underlying of  Dutpatient 3 DC  Time of Injury M  farm, street, factory  ge, deeth occurred	20A Other: 28c. Injury et Work? 1  Yes	6. Plece of Deel	24a. Was perfo	Yes 2 No an autopsymmed? Yes 2 No one) denca 6 Ott now injury occu  Street and Num wn, State) ceuse(s) and m	ontribute to the 3 Probabl 24b. Were evellet comple of deel 1 Yes	e cause of dealy  4 Unkn autopsy finding ble prior to stion of cause th?  ss 2 No
	A hours after death.  Funder Director: After this certificete has been signed by the ettending tely filled in by the funeral director, page 2 should be detached for use as	edical Certification: To Be Completed by Physician/Medical	Part II. Other significant conditions  25. Was case referred to medical examiner?  1 Yes 2 No  27. Menner of Death  1 Netural 5 Pending Investiga 3 Suicide 6 Could no determin  29a. Certifler (Check only one)	Hospital: 1 Inpatier  28e. Dete of Injun (Month, Dey tion to be ed 28e. Place of Injun building, etc.)  Physician: To the best of taminer: On the basis of taminer: On the basis of taminer:	Due to (or as a Due to (or as	e consequence of):  a consequence of):  g in the underlying of  Dutpatient 3 DC  Time of Injury M  farm, street, factory  ge, deeth occurred  and/or investigation	20A Other: 28c. Injury et Work? 1  Yes y, office et the time,	6. Plece of Deel	24a. Was perfo	Yes 2 No an autopsymmed? Yes 2 No one) denca 6 Ott now injury occu Street and Num wn, State) ceuse(s) and m date and piece.	ontribute to the 3 Probabl 24b. Were a evellet comple of deel 1 Yes	e cause of dealy 4 Unknown utopsy finding lele prior to stion of cause th?  ss 2 No
DAVID 5. DUND 6.5 W. MALPHA	The print of the control of the cont	edical Certification: To Be Completed by Physician/Medical	Part II. Other significant conditions  25. Was case referred to medical examiner?  1 Yes 2 No  27. Menner of Death  1 Netural 5 Pending Investiga 3 Suicide 6 Could no determin  29a. Certifler (Check only one)	Hospital: 1 Inpatier  28e. Dete of Injun (Month, Dey tion to be ed 28e. Place of Injun building, etc.)  Physician: To the best of taminer: On the basis of taminer: On the basis of taminer:	Due to (or as a Due to (or as	e consequence of):  a consequence of):  g in the underlying of  Dutpatient 3 DC  Time of Injury M  farm, street, factory  ge, deeth occurred and/or investigation	2DA Other: 28c. Injury et Work? 1  Yes y, office et the time, , In my opini	6. Plece of Deel  A Nursing Ho  s 2 No  date and place, ion, deeth occur	24a. Was perfo	Yes 2 No an autopsymmed?  Yes 2 No one) denca 6 Ott now injury occu  Street and Num vn, State)  ceuse(s) and m date and piece, 29d. Dete signe	Dontribute to the 3 Probabl 24b. Were a eveileb compy of deel 1 Year anner as stated, and due to the ed (Month, Day)	e cause of dealy 4 Unknown utopsy finding ole prior to ostion of cause th?  Solution Number, on cause (s)  A cause (s)  A year)



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 0 0 AVId 1999 AM /Medical 4c. County of Death Baltimore 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) Examiner Baltimore crest If Under 1 Year 9. Birthplaca (Stete or Foreign Mary) and 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) **Funeral** 216-58-3102 Days 44 Months Hours Min 10 M 20 F Yrs. Director Usual Residenca of Decedent the Marylend 10e State 10b. Count 10c. City, Town or Location 10d. Inside City Limits. 7 is marked other than "natural", or items 23s or 28s-f show traumstic evant, the Medical Examiner must be notified at 1 ☐ Yas 2 € No Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code 2122 nited Funeral 72 hours efter deeth Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Maritai Stetus Black, White, etc. 1/71-1 Nevar Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced 2/77 Completed 16a. Decadent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) filed within Eiementery/Secondary (0-12) College (1-4or 5+) Hygiene. mechanic Heating 18. Mother's Name (First, Middle, Meiden Surneme) 17. Fether's Name (First, Middle, Last) Be 2 should be figer Ernest becratt I rene-Informant's Name/Reletionship (Type 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 end 2 si ment of Health en ant: If ham 27 is n Oakland Kd 20b. Placa of Disposition (Name of cometery, cremetory or other place) 20a. Method of Disposition City or Town, State permit. Pages Department of Important: If it eny injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from Stata Pine Grove 5 Other (Specify) emeter 4 Dogation 6 22. Name end Addrass of Facility nickFringral Sarvice Ambrose tome of Lansdaune 2719 Hammonds Ko Lansdown telly 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one ceuse on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximata Intervel Between Onset and Death **Physician** /Medical fmmediate Ceuse (Final unth diseese or condition resulting in deeth) **Examiner** Physician/Medical Examiner ettending physician end for use es the buriel-transit Sequentially list conditions, if any, laeding to immadiate causa. Entar Undarlying Ceuse (Diseese or injury that initiated events rasulting in death) Last Due to (or es e consequence of) Due to (or as a consequence of) 23b. Dfd tobacco use contributs to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown signed by à 24b. Were eutopsy findings available prior fo Completed 24e. Wes en eutopsy peen s completion of cause of deeth? page 2 s hes 1 Yes 200No certificate 1 ☐ Yes 2 ☐ No or Attending Physician: director. Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Hospica Certification: To 1 Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatienf 3 ☐ DOA within 24 hours after death. To the Funeral Director: After this funeral 28a. Dete of Injury (Month, Dey Yeer) 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28c. tnjury at Work? 19 Naturel 5 Pending 1 Yas 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and menner es stated. edicai completely (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end pleca, end due to the cause(s) end menner steted.

State Registrar

JUN 0 1 1999

29b. Signature end title of certifier

A.

Gbmc 32. Registrar's Signature

no

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

6781 N. Chales St. Bulto. Md 31908 oaks

025205

29c. Licensa number

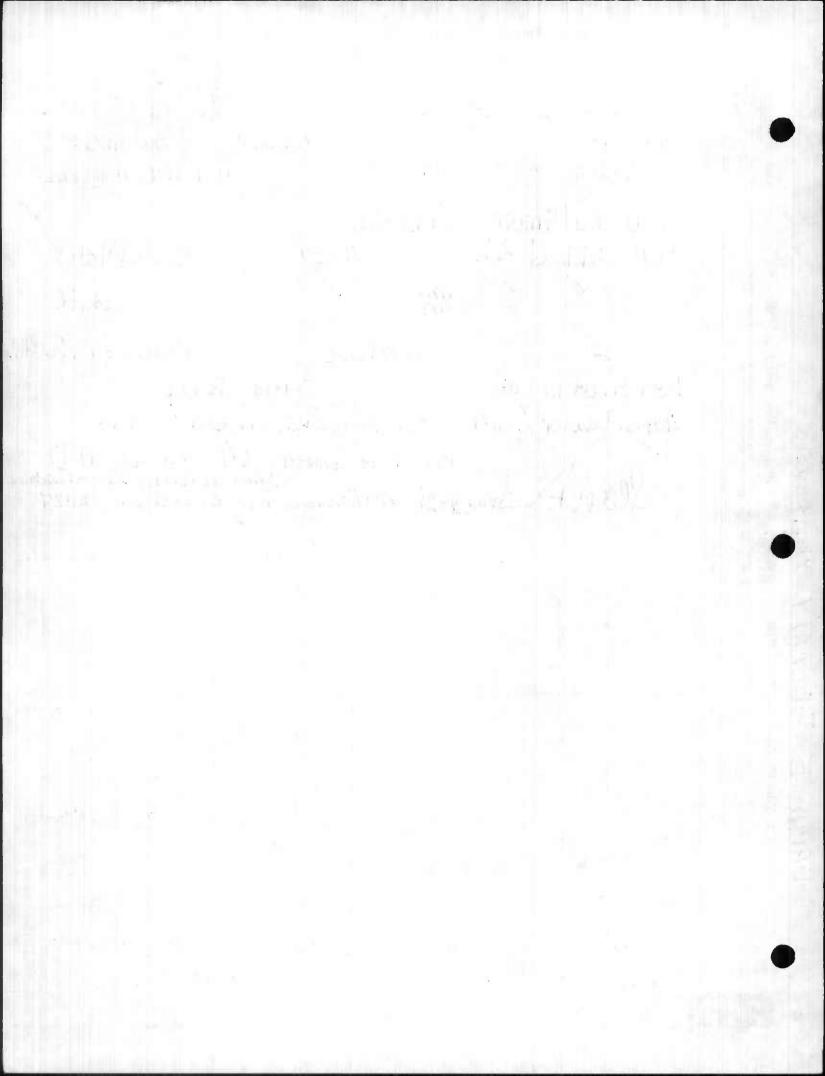
29d. Date signed (Month, Day, Year) 129,1999

DHMH 16 Rsv 6/95

To

66

BECRAFT



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Deeth 3. Time of Death **Physician** Betty Browning May 28, 1999 Jean 2:15pm /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Baltimore Towson If Undar 24 Hrs. 5. Social Security Number If Undar 1 Yaar 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) 9. Birthplece (Stete or Foraign Country) **Funeral** Months Deys Hours Min 1 M 2 X F Yrs. **Director** 215-34-6719 63 Feb 1, 1936 Pennsylvania Usuel Residence of Decedent the Marylend 10a Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f show 1 ☐ Yes 2 ☒ No Directo Maryland Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? permit. Pages 1 and 2 should be filed within 72 hours effer death with Department of Health and Mental hygiene. Important if from 27 is marked other than \*--- any injury or other treument. r than "natural", or items 23s or the Medical Examiner must be 105 Margate Road 21093 Funerai USA 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedant of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Bieck, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Giva Yeer or Detes: 1 Nevar Marriad 2 Married 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) Health Care 12 02 18. Mother's Name (First, Middle, Malden Sumame) 17. Father's Neme (First, Middle, Last) Robert Henry Mundy Frieda Virginia Bailey 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informeni's Name/Reletionship (Type, Print) Robert Charles Browning/Husband 105 Margate Road, Lutherville, MD 21093 20b. Pieca of Disposition (Neme of cametery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 X Buriel 2 ☐ Cremetion 3 ☐ Removei from State 4 □ Donation 5 Ø Other (Specify) Dulaney Valley Mem. Grdns. 6/1/99 Timonium, Maryland eryice Licepate 22. Nema end Addrass of Facility Simon Lemmon Lemmon Funeral Home Per Letter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or haert feitura. List only one cause on each line. 21093 Approximate Intervel Between Onset and Death **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical CAncer una Examiner Examine The law requires that the death certificate be executed physicien end the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in deeth) Last Due to (or as e consequença of): Physician/Medicai Due to (or es e consequenca of): 98 980 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by t 1 XYes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed nis certificete has by director, page 2 st 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) H Spice 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury et Work? Certification: 28e. Dete of Injury (Month, Day Year) 5 Pending investigation Attending 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after deeth Director: / 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide thin 24 hours after the Funeral Dire mpletely filled in the 6 12 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end pieca, end due to the ceuse(s) end menner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end pieca, and due to the cause(s) end menner stated. 29a. Certifier (Check only one) within 2 29d. Dale signed (Month, Day, Year) 29c. License number c cus) 30. Name and eddress of person who comp cause of deeth (Itom 231) (Type, Print) N. Charles St. Balto. nd 2120x

68mc

32. Registrer's Signature

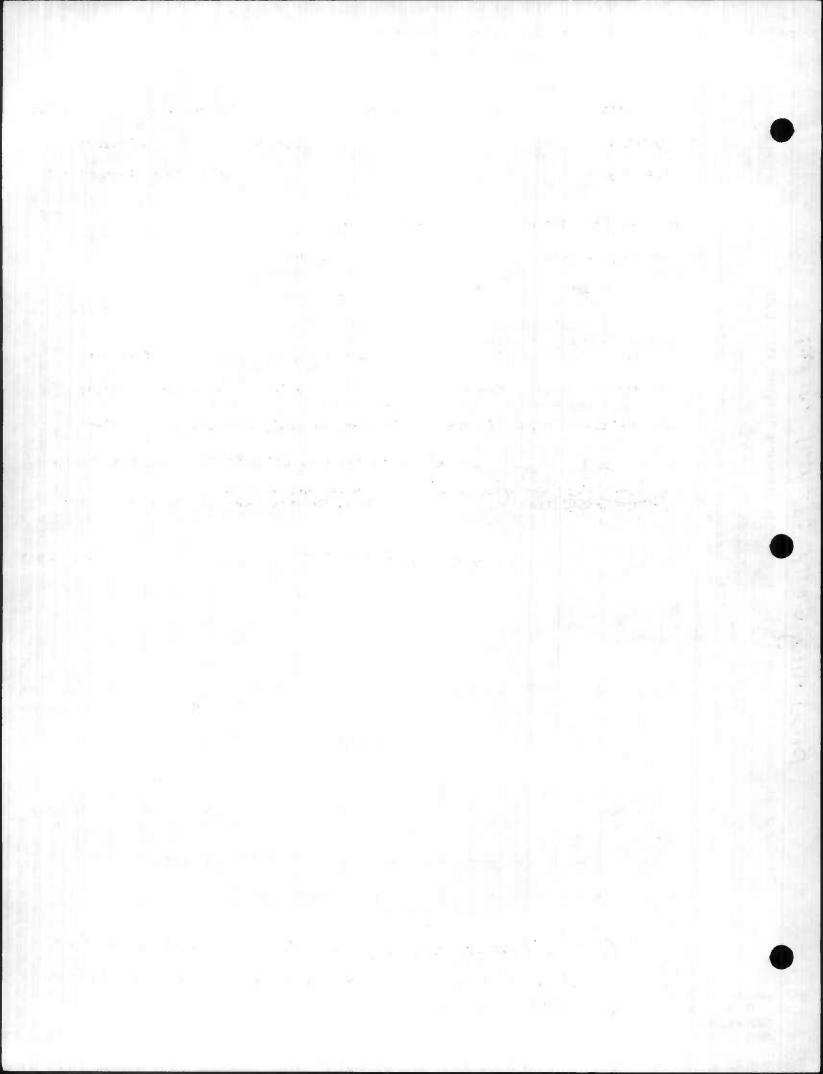
Kilei

1999

State Registrar

DHMH 16 Rev 6/95

Srowning, Be



### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** Clarence 26, 1999 Broady 6:53PM MAY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Undar 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (in yrs. lest birthdey) Birthplace (State or Foraign Country) **Funeral** Days 1 M 2 □ F 76 Yrs Director 05-15-23 NC 242-26-1338 Usual Rasidence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show X1 Yes 2 □ No MD Directo Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2311 Aiken Street 21218 USA Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian Bleck, White, etc. treumatic event, the Medical Examiner. TY Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married ò Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black "naturel". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Spacify only highast grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Roofer Bethlehem Steel Co. 12th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental Alex Broady Minnie 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 21218 19a. Informent's Neme/Relationship (Type, Print) Lucille Broady Mem 27 2311 Aiken Street Baltimore, Maryland 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata MD permit. Pages Department of Important: If It any Injury or o Removal from State 4 □ Donation 5 □ Other (Specify) Garrison Forest VA Cem. 06-02-99 Owings Mills, 22. Nama and Addrass of Facility Baltimore, Maryland 21202 21. Signature of Funeral Service Licenses WM.C.March FH 1101 E. North Avenue Wee mplications that caused the desun. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. int1. Enter the disease, or only mock, or heart failura. List or ly Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disaasa or condition resulting in death) 6 well ance **Examiner** Due to (or es e consequence of) Examiner the attending physician end hed for use es the bunal-transit death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting In death) Last Due to (or as a consequence of) Box 68760 Physician/Medical Due to (or as a consequence of): 98 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by to 1 Yes 2 No 3 Probably 4 Unknown þ The law requires 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed been s completion of ceuse of death? certificate has 2 No 1 ☐ Yes 2 ☐ No Division of Vital Physician: 25. Was cese referred to medical examiner? Be 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending Natural 2 Accident 5 Pending Investigation 1 Yas 2 No I Director: A death. 28f. Location (Street end Number or Rural Route Number, City or Town, Stefe) 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end piece, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) and manner stated. edicai 29a. Certifier (Check only one) 29c. License number 29d. Date signad (Month, Day, Year) 29b. Signature and title of certified heatil d 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Baltimore,

6701 32. Registrar's Signature

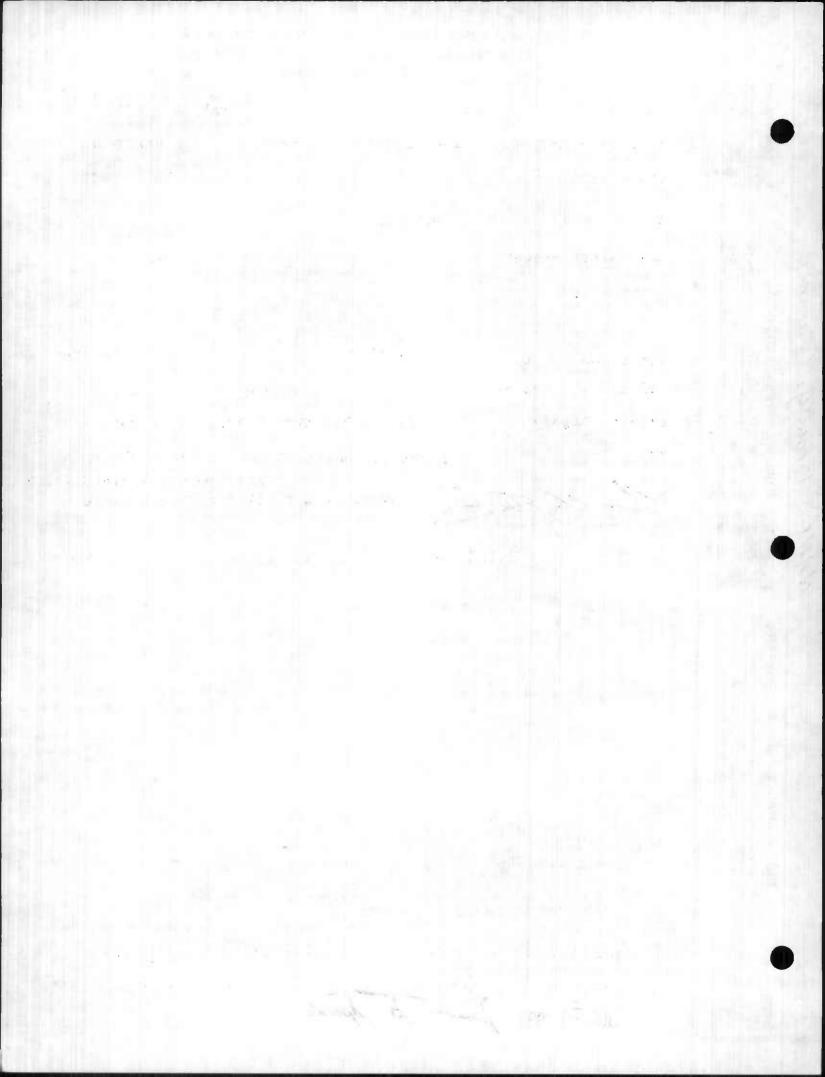
Registrar **DHMH 16 Rev 6/95** 

State

31. Date filed (Month, Dey, Year)

Clarence

3roady,



Please Type or Print in Black indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 Certificate of Death AMENDED ITEM #10b PER FH 6/1/99 AH 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 10:55PM 1999 28 MARGUERITE LEIPOLD BULL /Medical 4b. City. Town, or Location of Death 4e Fecility Neme (If not Institution, give street end number) 4c. County of Death Examiner Union Memorial Hospital Baltimore N/A If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dey, Year) **Funeral** 1□M 2\ F Months Devs Hours Yrs. Director 214-24-0319 Apr 22, 1924 Maryland Usuel Rasidence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-1 show 1 ☐ Yes 2 No BALTIMORE Directo Perry Hall Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a or 2 any Injury or other traumatic event, the Medical Examine must be an once. 9 Arlen Road 21236 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 14. Reca - American Indien, Bleck, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 11. Meritel Stetus 1 ☐ Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White P 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 12th Homemaker Own Residence 18. Mother's Nema (First, Middle, Malden Sumeme) 17. Fether's Neme (First, Middle, Last) John Thomas Leipold Marguerite Teresa DeWeese 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Amanda E. Bull (Daughter)
20e. Method of Disposition 9 Arlen Road, Baltimore Maryland 21236

20b. Plece of Disposition (Name of cametery, cremetory or other place) 1 N Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) St Mary's Ch Cemetery
22. Name and Address of Facility 6/2/99 Homeland, Maryland 21. Signefure A Funeral Service Learning Mitchell-Wiedefeld Funeral Home, Inc. 23a. Pent. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest,

Approximately 10 in the caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest,

Approximately 10 in the caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximete Intarval Batween Onsat and Deeth **Physician** pericardial effusion Immediata Causa (Final disaase or condition resulting in death) /Medical 24 hours Examine Examiner physician and the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): 980 signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert f. 1 Yes 2 No 3 Probably 4 Unknown Hypertension þ 24b. Wera autopsy findings available prior to completion of cause of deeth? Coronary artery Disease 24e. Wes en eutopsy performed? Completed s certificata has b yperlipidemia 1 Vas 2 No 2 17 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case ratarred to medical examinar? Be 26. Pleca of Deeth (Check only ona) Other: 4 Nursing Home 5 Residanca 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Menger of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28d. Describe how Injury occurred 28c. Injury at Work? After 1 Naturel 5 Pending death. investigation 1 ☐ Yes 2 ☐ No after death Director: A d in by the f 2 Accident 3 Sulcide 6 Could not be determined Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Pieca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida within 24 hours aft To the Funeral Dis completely filled in 29e. Certifier 1🗹 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end piece, end due to the causa(s) and manner as stated. Medical (Check only one) 2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred et the Ilme, dete end pleca, end due to the ceusa(s) end manner stated. within 2 \$ 29d. Dete signed (Month, Day, Year) 29c. License number 0 AT2438946 May 28, 1999

Baitimore

Maryland 21218

201 East University Pkwy

State Registrar Shawn

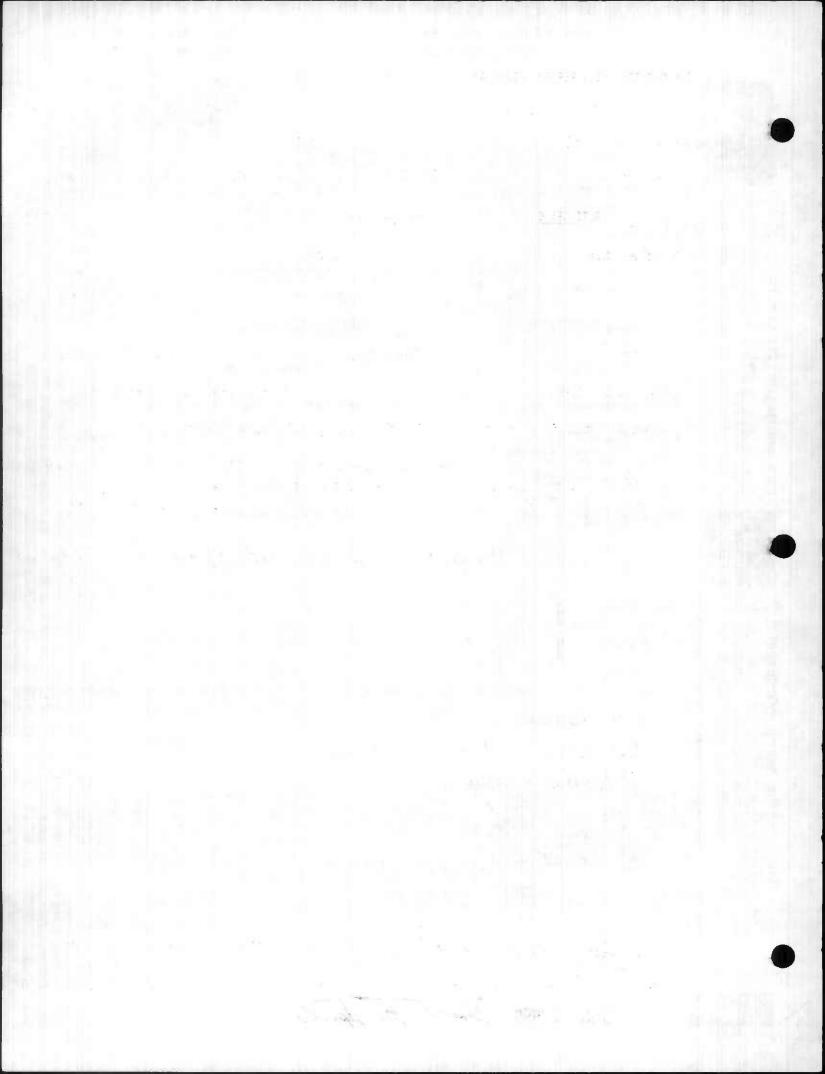
31. Dete filed (Month, Dey, Year)

30. Name end eddrass of person who complated cause of death (Itam 23e) (Type, Print)

Dhillon,

M.D.

32. Ragistrar's Signeture



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q

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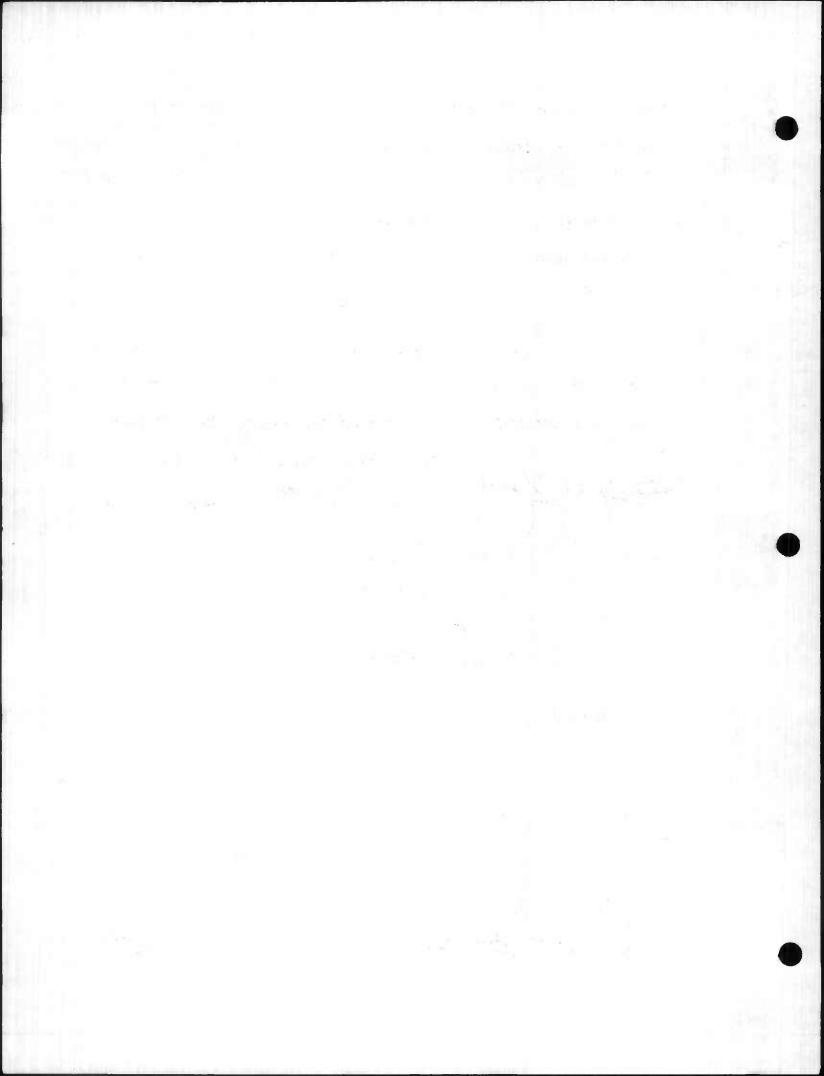
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tims of Deeth **Physician** Month MAY 25,1999 George Litchfield Counts, Sr. 6:10 AM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON
If Under 24 Hrs. 8. De BALTIMORE 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1QM 2□ F Days Hours Min. Virginia Director 218-18-1440 81 Usuai Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumetic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No MD Baltimore Cockeysville 10e. Street and Number 10f. Zlp Code 10g. Citizen of Whet Country? 6 items 23a USA 800 Warren Road 21030 Funeral Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bieck, White, etc. 1 Yes 2 (No If Yes, Give Year or Dates: 1 Never Married 2 Married 'natural', or 1 ☐ Yes 2 ☑ No Specify: White by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/industry permit. Pages 1 and 2 should be filed within: Department of Health end Mental thygiene. Important: if Itam 27 Is marked other than \* any Injury or other traumetic svent, in Med 9008. College (1-4or 5+) Elementery/Secondary (0-12) Housing n/a Carpenter 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Thomas Lochard Counts Anna Frances Ingram 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 800 Warren Rd., Cockeysville, MD 21030 Bonnie O. Counts/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stele 5/28/99 1 X Buriel 2 ☐ Cremation 3 ☐ Removel from Stete Dulaney Valley Memorial Gardens Timonium, MD 21093 4 Donstion 5 Other (Specify) ral Service tice 22. Name and Address of Facility Lemmon Funeral Home Bryan W. Clar 10 W. Padonia Rd., Timonium, MD 21093 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, disease, or complications. List only one ions that caus Approximete Intervel Betw **Physician** /Medical Immediate Cause (I disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner allera The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or as e consequence of) and physician a Box 68760, Physician/Medical Due to (or as a consequence of) ever P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the 1 | Yas 2 | No 3 Probably 4 ☐ Unknown signed b Division of Vital Records. þ 24b. Were autopsy findings evallable prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 : 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifics completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 1 Matural 5 Pending 1 Yes 2 No Investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Medicai 29a. Certifier 1🕰 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner es stated. 2 Msdical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

5 26 99 29b. Signature and title of certifie 29c. License number 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) 101m000 31. Dete filed (Month, Day, Year) JUN 0 1 1999 32. Registrar's Signature

Registrar **DHMH 16 Rev 6/95** 

State



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Month **Physician** CRUICKSHANK WILLIAM 5 12:40A 29 99 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner OF MARY LAND HOSPITAL BALTIMORE UNIVERSITY 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplace (Stete or Foreign Country) **Funeral** Months Days 1⊠M 2□F Hours 216-16-5653 Director 06-27-1924 Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10h County 10c. City. Town or Location "natural", or items 23a or 28a-f show solical Examiner must be notified at 1 ☐ Yes 2 ☐ No Maryland Directo Howard Ellicott City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with Hygiene. 2902 Ramblewood Road 21042 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Giva 1 Q 4 2 - 4 Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, 11. Marital Status Black, Whita, etc. 1 Never Married 2 Married If Yes, Giva 1942-46 Yaar or Datas: 1 ☐ Yes 2 ☑ No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed permit. Pagas 1 and 2 should be filed within 72 ho Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natur any injury or other traumatic event, in exerci-16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 Year 12 Years Rocket Scientist Dept. of Defense 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) William John Cruickshank Elsa Schroed1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2902 Ramblewood Road Ellicott City, MD 21042 Anna Lambert Cruickshank-Wife 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) Date 6-2 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 X Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Baltimore- Wash. Crematory 1999 Laurel, Maryland 21. Signature of Funeral Sarvice Licensae 22. Nama and Addrass of Facility Loring Byers Funeral Direcotrs, Inc. J. Wayne Osterling 8728 Liberty Road Randallstown, MD or the classes, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, earl failure. List only one cause on each line. 21133 Approximata Interval Between Onsat and Death **Physician** /Medical Immediate Ceuse (Final ACUTE MYELOGENOUS LEUKEMIA disease or condition resulting in deeth) Examiner Examiner physician and the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in death) Last Due to (or es a consequence of): Physician/Medical Due to (or as a consequence of) signed by the a Part II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 WUnknown PULMONARY FIBROSIS g 24b. Ware autopsy findings available prior to completion of ceuse of death? should should Completed 24a. Was an autopsy performed' s certificate had 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospitat or Attending Physician: 24 hours after death. Funeral Director: After this certified director Be 25. Was casa referred to medicel examiner? 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2No Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Dey Year) 27. Mannar of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No investigetion rector: A 2 Accident 6 Could not be 3 ☐ Sulcide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b 1≅Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the ceuse(s) end menner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and plece, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Data signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier P11764 5/29/9 RESIDENT 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

SAPNA KMEHL, MD DEPT. OF MEDICINE, UNIVERSITY OF MARYLAND HOSPITAL

432. Registrar's Signatura

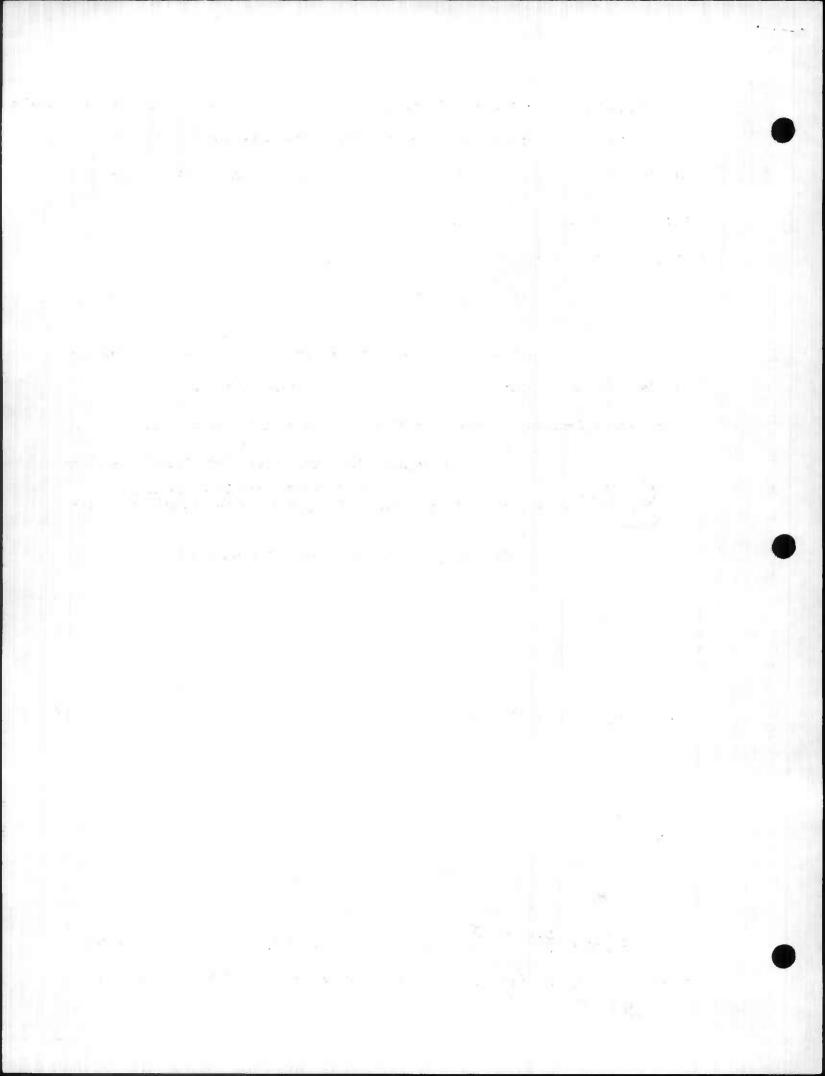
State Registrar

DHMH 16 Rev 6/95

DMN 6 20885

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death MAY 1999 28 1357 L Frank Coleman 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Agnes Hospital Baltimore If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months 1 M 2 F Yrs. 224-16-2380 09-13-1915 Virginia Usuel Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Arbutus Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 U.S.A. 5550 Ashorune Road 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Marital Status 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WW I 1 Never Married 2 Merried 1 ☐ Yes 2 ☐ No Specify. Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Years n/a Yard Worker Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Parker George Bell Coleman Lillian 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Margaret Pearre-Personal Rep 625 Warwick Road Baltimore, Maryland 21229 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removet from State 4 ☐ Donation 5 ☐ Other (Specify) Pleasent Valley Cemetery 6-2-99 Westminster, Maryland 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Loring Byers Funeral Directors, Inc. Wayne Osterling 8728 Liberty Road Randallstown, MD 21133 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, or heart ailure. List only one cause on each line. Approximete Intervel Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Cotos COLOV vesse Due to (or as a consequence of) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yaa 2 ☐ No 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? dro Cestero 1. Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 | EN/Outpatient 3 | DOA 28e. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical Examiner

Examiner

Physician/Medical

Be Completed by

Medical Certification: To

Netural

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

28a-f show

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Department of Health I Important: If Item 27 is any Injury or other tra

Pages 1 and 2 should be nent of Health and Mental

hours after

altimore, Maryland 21215-0020

Directo

Funeral

Completed

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After

after death Director:

• Funeral

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Box 68760 COLEMAN Vitai Hospital or Attending Physician: of Division

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Registrar DHMH 16 Rav 6/95

State

Krain 31. Date filed (Month, Day, Year) JUN 01

29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

756 Com 30. Name and eddress of person who completed cause of death (flem 23a) (Type, Print) Com

Soull 700 32. Registrar's Signature

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

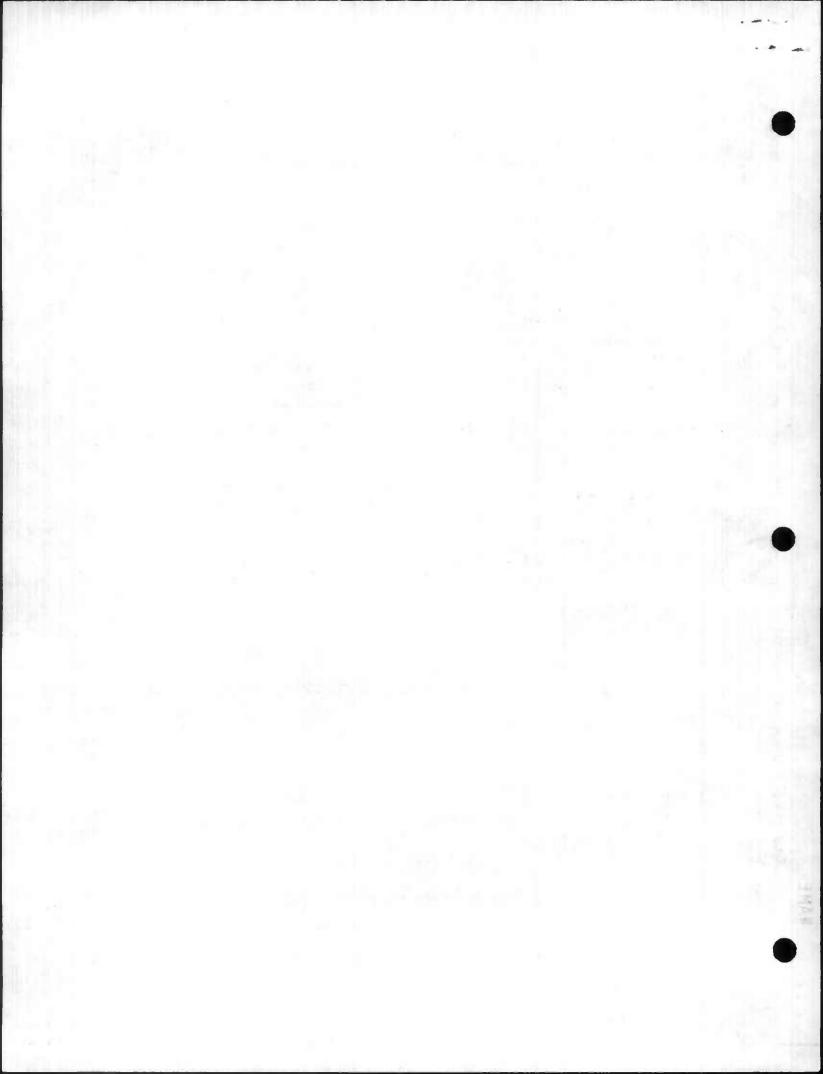
1 Yes 2 No

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the ceuse(s) end menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end manner steted.

29c. License number

29d. Date signed (Month, Dey, Year)

281. Location (Street and Number or Rural Route Number, City or Town, Stete)

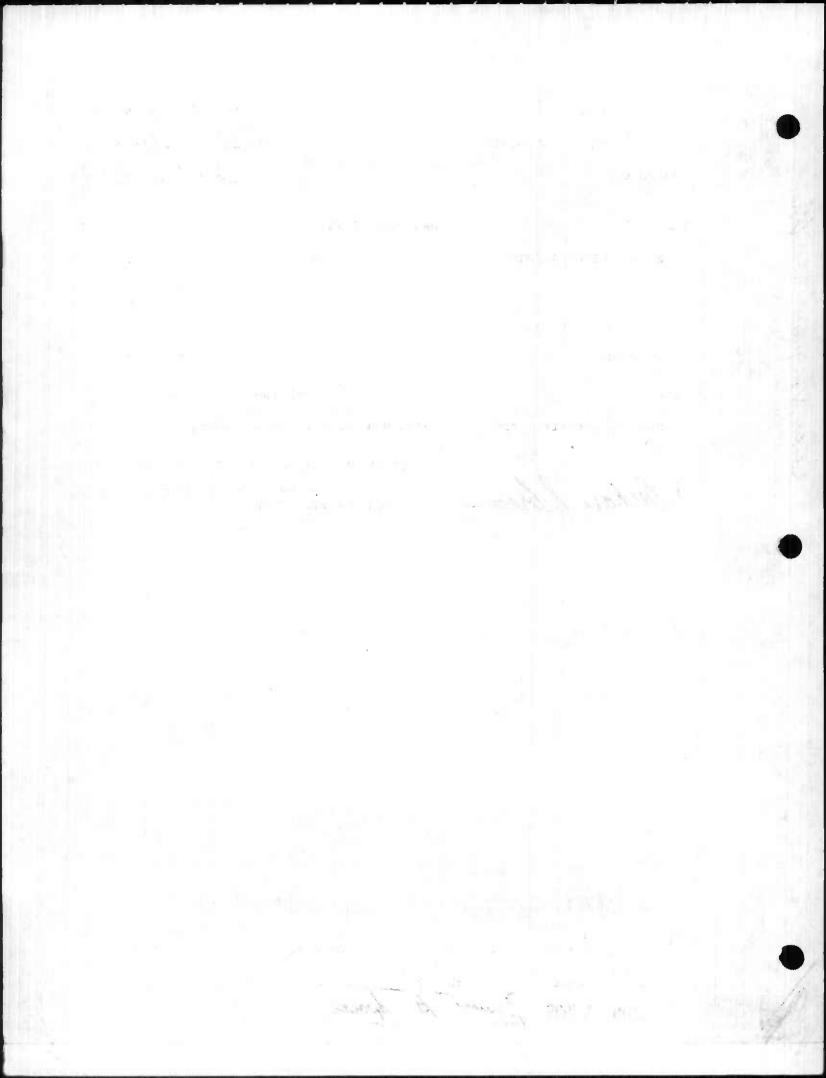


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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month 6:10 am VIRGINIA CARR MAY 1999 /Medical 4e. Fecility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner FUTURE CARE OF OLD COURT PIKESVILLE BALTIMORE 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 7. Age (In yrs. lest birthday) **Funeral**  Birthplece (State or Foreign Country) Deys Hours 1 M 2 X X 75 Yrs. Director 220-20-6322 AUG 20 1923 VIRGINIA Usual Residence of Decedent the Maryland 10a. Stete 10h County 10c. City, Town or Location 10d, Inside City Limits 28a-f shov the Medical Examiner must be notified at Director 1⊠Xes 2□No MARYLAND N/A BALTIMORE CITY 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ŏ items 23a 2259 MADISON AVENUE 21217 U.S.A. 11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 XXo ŏ 1 ☐ Yes 2 ☑ Specify: Specify: BLACK þ 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry marked other than Elementery/Secondery (0-12) . Hygiane. College (1-4or 5+) HOME CARE 12th grade DOMESTIC permit. Pages 1 and 2 should be file Department of Haalth end Mantal Hy important: If Itam 27 is marked other any injury or other traumatic event 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be unknown unknown 19e. Informent's Neme/Relationshtp (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael T. Tisdale/Godson 2424 Madison Avenue, Baltimore, Maryland 21217 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Steta 1 ☐ Bariel 2 ☐ Cremetion 3 ☐ Removet from Stete 4 ☐ Donetion 5 ☐ Other (Specify) ARBUTUS MEMORIAL PARK 6-4-99 BALTIMORE, MARYLAND Signeture of Funeral Service Licens 22. Name end Address of Fecility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete tntervel Betw Onset end Deeth **Physician** of colon to liver /Medical Immediete Ceuse (Finel diseese or condition resulting in death) Carcinoma months Examiner Due to (or es e consequence of): Examir attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentielly tist conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or es e consequence of): signed by the a d be detached f P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dtd tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Records, by 24b. Were autopsy findings evalleble prior to completion of cause of deeth? paga 2 should Completed 24e. Was en eutopsy performed? 1 🗆 Yes 20 No 1 ☐ Yes 2 ☐ No certificata of Vital or Attending Physician: director, Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 42 Nursing Home 5 Realdence 8 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA this funeral 27. Menner of Deeth Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred Certification: After Division 1 Netural 5 Pending investigation s after death. Il Director: Aft ed in by the fu 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcide 28e. Ptace of Injury - At home, farm, street, fectory, office building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide Mospital 24 hours a Funeral D 1 Cortifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner as steted.
2 Medical Examiner: On the basts of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner steted. 29e. Certifier Medical completely (Check only one) To the within 2 29b. Signeture end title of cadifie 29c. License number 29d. Dete signed (Month, Dey, Year) D0020964 05/27/99 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Jerome H. Ginsberg, M.D. 8630 Liberty Plaza Mall Randallstown, MD 21133 32. Registrar's Signeture 31. Dete filed (Month, Day, Year) 1999 State Registrar



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31. Dete filed (Month, Dey, Year)

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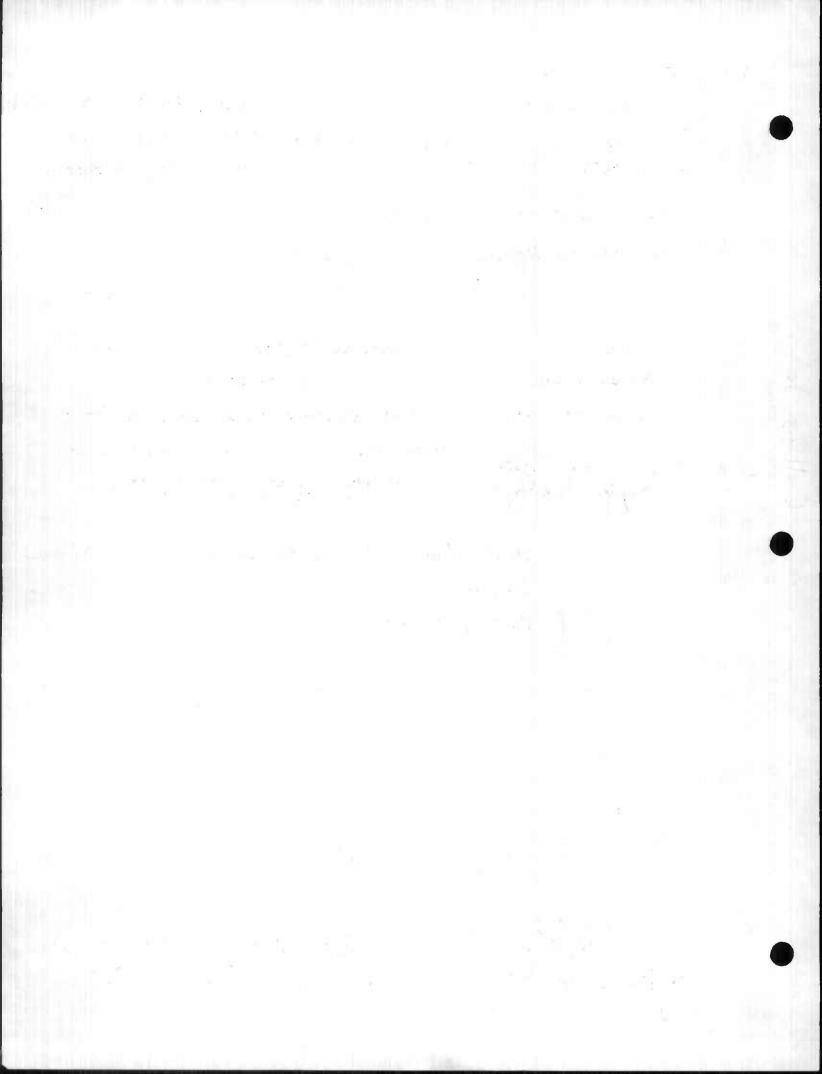
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DHMH 16 Rev 6/95

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Registrar



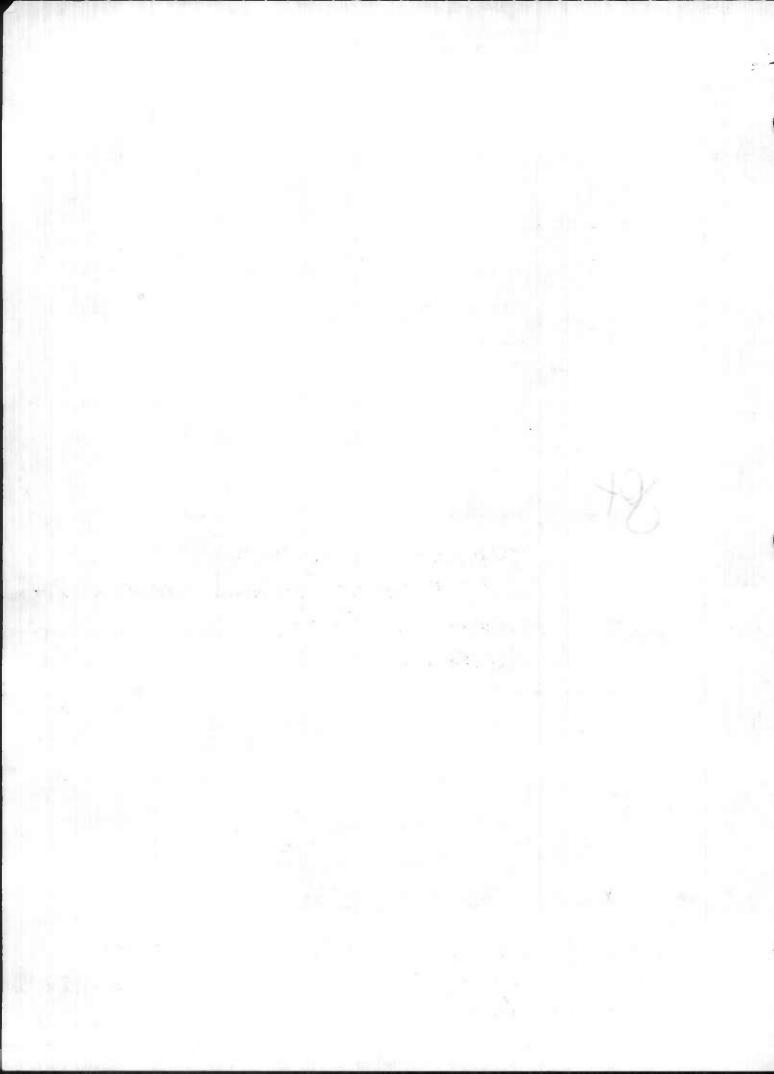
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 1999 Harold Daughton 3 May 6:45 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner Health of North Arundel Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1₩ 2□ F Director 187-03-2725 Feb. 27, 1918 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. fnside City Limits ahon 1 ☐ Yes 2☐No Director Maryland Baltimore Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? THE 23s OF filed within 72 hours etter death with Hygiene.
ther than "natural", or flems 23s or 202 Slade Ave. 21208 Funeral U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Ki Yes 2 No
If Yes, Give
Year or Dates: 1942-45 "natural", or Itan Bleck, White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify: 21215-0020 b 3 Nidowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Years N/A Welder i. Pages 1 and 2 should be filed w traint of Health and Mantel Hygier tant: If Item 27 is marked other to jury or other treumstic event, to Tank Lining Baitimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Charles Daughton Emily Jones 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Daughton Cook-Daughter 3465 Brookhaven Road, Pasadena, Maryland 21122 20a. Mathod of Disposition

1 Buriaf 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete permit. Page Department of Important: If eny Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial Park 5-28-99 Sykesville, Maryland 22. Name and Address of Facility
Loring Byers Funeral Directors, Inc. 21. Signatury of Punisral Service Licenses 8728 Liberty Road, Randallstown, Maryland 21133 J. Wayne Osterling 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, that, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical MONTH Examiner Physician/Medical Examiner nding physician and use as the burief-transit The law requires that the death certificate be associted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last oreprovuscular eas Due to (or es a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Were autopsy lindings available prior to completion of cause of death? Completed 24e. Wes an autopsy page 2 1 ☐ Yes 2 No 1 Yes 278 No Vital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 8 26. Place of Deeth (Check only ona) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To ot After this 28a. Date of Injury (Month, Day Year) 27. Manner of Dea 28d. Describe how injury occurred 28c. Injury at Work? Division 1 Natural 5 Pending investigation s after death. 1 ☐ Yes 2 No 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of fnjury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 Homicide 24 hours Hospital 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Cal 29a. Certifier within 2 To the 29b. Signatury III 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) Suite 304 Sevene Purk, MD 21146 Tumpers 479 D 33/ Registrar's Si State Registrar **DHMH 16 Rev 6/95** 

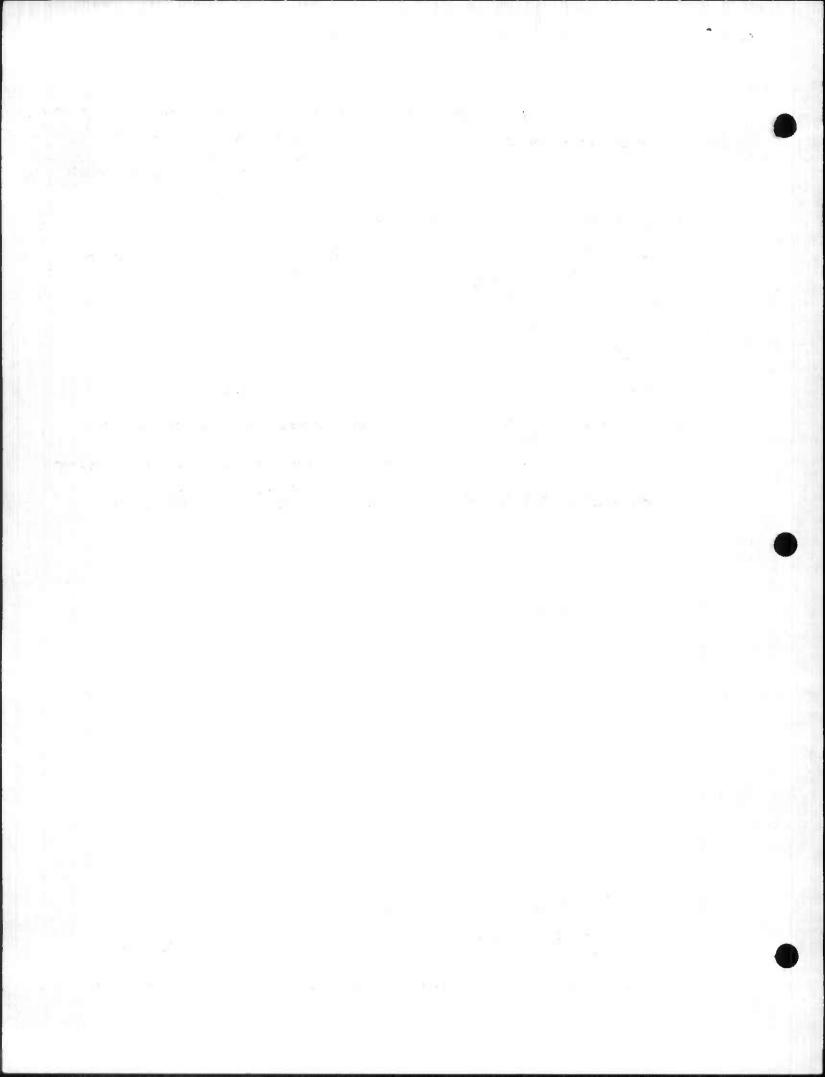
ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** 30-1999 10:30 DICK BERTHA MAY /Medical 4a. Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Randallstown Baltimore Robosson Court Nursing Home | If Under 1 Yeer | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. June 9, 1901 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplace (Stete or Foreign **Funeral** 10M 20F 97 Maryland 212-74-2478 Yrs. **Director** Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "naturet", or Items 23a or 28a-f show eny Injury or other treumstic event, the Medical Examiner must be maritimeter 10s. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Timonium Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 5 Wingate Garth United States Funeral 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Meritei Stetus 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 Nidowed 4 Divorced White 18e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind ot Business/Industry College (1-4or 5+) Elementary/Secondery (0-12) 9th Grade Homemaker Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Joshua Dick Stella McCann 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dee L. Jungers - Daughter 5 Wingate Garth; Timonium, Maryland 21093 20b. Piace of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removei from Stete 4 ☐ Donation 5 ☐ Other (Specify) Emory Meth. Church Cem. 6/3/99 Streett, Maryland 21. Signeture of Funeral Service Licenses 22. Neme end Address of Fecility Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133 23a. Part1. Enjer the disease, or compilections that cause shock, or heart feilure. List only one cause on each li deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximete Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) 2 DAYS Examiner Due to (or es a consequenca of) Examiner ANDREATIC physician and the burial-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Division of Vital Records, P.O. Box 68760, the death certificate be Physician/Medical Due to (or as e consequence of): esn for Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? ENGBROUASOULAN DISEASE þ GENERALIZED ARTERIOCCUEROSIS 24b. Were autopsy tindings evailable prior to completion of cause of death? 24e. Was en eutopsy Completed certificate has 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 28. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funerel 28b. Time of Injury 27. Menner of Death 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Naturel al or Attending after deeth. Director: After 1 Yes 2 No 2 Accident in 24 hous.
The Funeral Direction of the filled in by the 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify) 4 Homicide Hospital 24 hours 8 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and menner as stated. To the Hosp within 24 hor To the Fune completely fi Medical 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signeture end title of certifier 29d. Dete signed (Month, Day, Year) D-22609 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 7445 FURNACE BRANCH Rd Glen Burnie Md 21060 REIDER M.D. RUBEN 31. Dete tiled (Month, Dey, Year) 32. Registrer's Signature 1999 JUN 01 Registrar



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

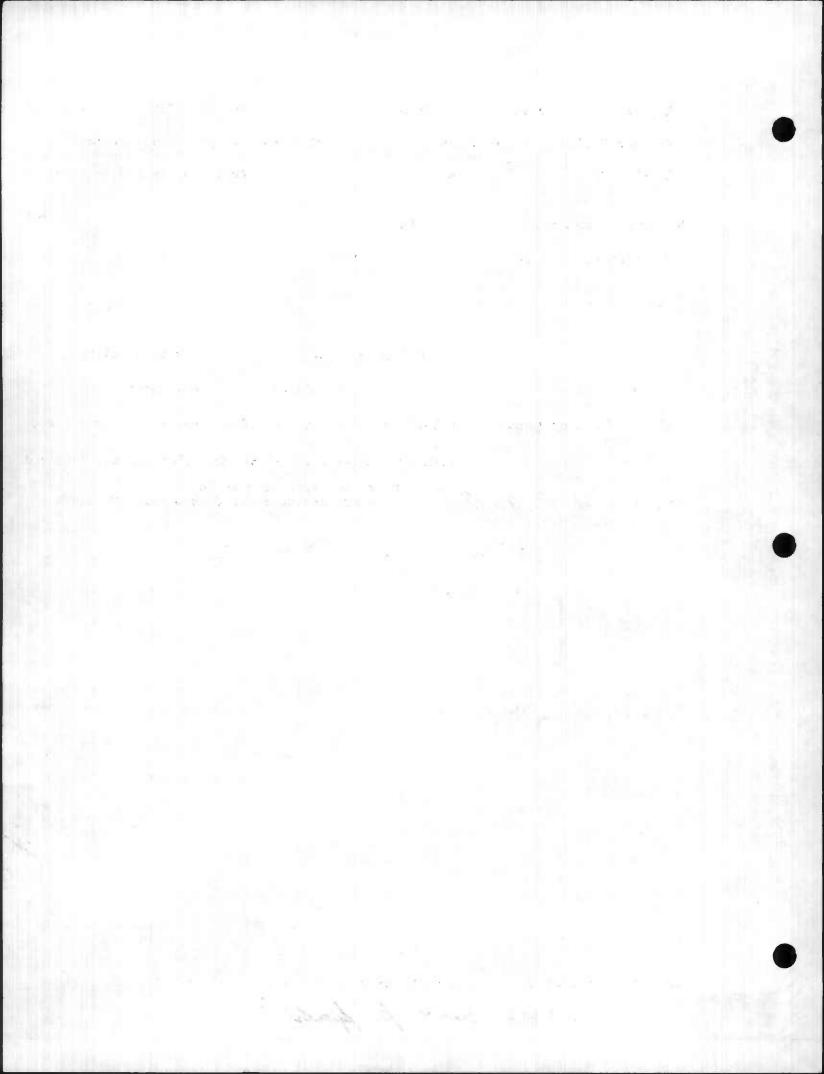
State of Maryland / Department of Health and Mental Hygiene ()

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Dev **Physician** May 28, 1999 1:50 AM The 1ma Theo Dean /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Death Examiner Anne Arundel Mariner Health of Glen Burnie Glen Burnie If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) 8. Sex **Funeral** 1□M XXF Deys Yrs. April 15, 1921 West Virginia Director 235-36-5292 Usual Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits worle 7 is marked other than "naturel", or Nems 23a or 28a-f show traumatic event, the Modical Examener must be notified at 1 ☐ Yes 2X No Directo Anne Arundel Maryland Glen Burnie 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with S. A. Funeral 21061 U. 414 Glenwood Avenue death Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Maritel Stetus Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Nem 27 is metical other than "naturel", or fire eny Injury or other traumatic event. It is 1 □ Never Merried 2 □ Married Baltimore, Maryland 21215-0020 1 Yes XX No Specify: Specify by XO Widowed 4 □ Divorced White Completed 16e. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Retail Sales 8 Office Manager 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Caroline Bumgardner Edge11 Emery 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Glen Burnie, Maryland 21060 Sharon Kirchmar (Daughter in Law) 529 Amberly Road 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, State 20e. Method of Disposition 1 ₺ Burlel 2 □ Cremetion 3 □ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Glen Haven Memorial Park 6/1/99 Glen Burnie, Maryland 22. Name end Address of Fecility 21. Signeture of Funeral Service Licenses Singleton Funeral Home PA 23a. Pert1. Enter the disease, or complications that carry of the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause or act line. 1 Second Avenue S. W. Glen Burnie, MD 21061 Approximete Intervel Between Onset end Deeth **Physician** 12 peimes, Biscase /Medical Immediate Cause (Finel diseese or condition resulting in death) Examiner Due to (or as a consequence of): Notri Examiner physician and the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest Due to (or es a consequence of). certificata be exe Box 68760. Physician/Medicai Due to (or es e consequence of): SB esn Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. PERMICIOUS 1 Yes 2 No 3 Probably 4 Unknown Anemia signed bedet Division of Vital Records. by 24b. Were autopsy findings evelleble prior to completion of cause of deeth? 24a. Wes an autopsy performed? Completed page 2 1 Yes 2 No 1 □ Yes 2 □ No certificate or Attending Physician: funeral director, 25. Wes case referred to medical 28. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 1 Yes 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury et Work? Certification: After 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Phyelcian: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated. 29e. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture end title of certifier BKiospick WO 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) ROBERT B. KROOPNICK, M.D., 795 AQUHART ROAD, SUITE 203, GLEN BURNIE, MD. 21061 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State sports)

Registrar

JUN



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month **JOAN** DEWICKI May 26, 1999 6:30PM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baynesyille Frynder 24 Hrs. 8. Date of Birth (Month, Day, Year) GENESIS FIDERCARE, LOCH RAVEN
5. Social Security Number 6. Sex 7. Age (In yrs. Is Baltimore County

9. Birthplaca (State or Foreign Country) ff Under 1 Yaar 7. Age (In yrs. last birthday) Days Months 1□ M 2⊠ F 216-14-0493 Usual Residence of Deceder Nov 30, 1918 Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baynesville Maryland Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8720 Emge Road 21234 USA 12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 11. Marital Status 14 Race - American Indian Black, Whita, atc. 1 Never Married 2 Married 1 ☐ Yas 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary MD State Gov't 4 yrs 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Hedwig Adam Beksinski Warczynska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Mrs. Hedwig M. Hisley, (Sister) 800 Southerly Road, Towson, Maryland 21204 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cametery, crematory or other place) Data 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 6/2/99 St. Stanislaus Cemetery 21. Signature of Funeral Servicer Donat Markin Mitchell-Wiedefeld Home awson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Maryland 21212 approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Metastic Breat Carcinoma 2 years Due to (or as a consequence of) Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco usa contributa to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 27 No 1 ☐ Yas 2 ☐ No

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

**Funeral** 

Director

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than "natural", or hama 23s or 28s-f show the Medical Examiner must be nothed at

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death

filed within 72 hours efter thyglene.

permit. Pages 1 and 2 should be filed wit.
Department of Health and Mentel tygiene Important: if item 27 is marked other tha any injury or other treumatic event, that page.

Baltimore, Maryland 21215-0020

Box 68760 P.O. Records, page 2 : certificate has Vitai

physicien end the buriel-transit The law requires that the deeth certificate be executed Division of this funeral After Attending s efter death. à

Immediate Cause (Finat disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Malnutrition à Completed Dementia- Alzheimer's 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4N Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yes 2 No 10 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Natural
2 Accident 5 Pending 1 Yas 2 No investigation 6 ☐ Could not be determined 3 Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours effer To the Funeral Directompletely filled in by 1 Certifying Physician: To the best of my knowledga, death occurred at tha tima, data and place, and dua to tha ceuse(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha ceuse(s) and manner stated. 29a. Certifier edical (Check only one) 29b. Signature and the of contil 29c. License number 29d. Data signed (Month, Day, Year) tem 5-28-1999 D28987

State Registrar

Carl

31. Data filed (Month, Day, Year) 1999

DHMH 16 Rev 6/95

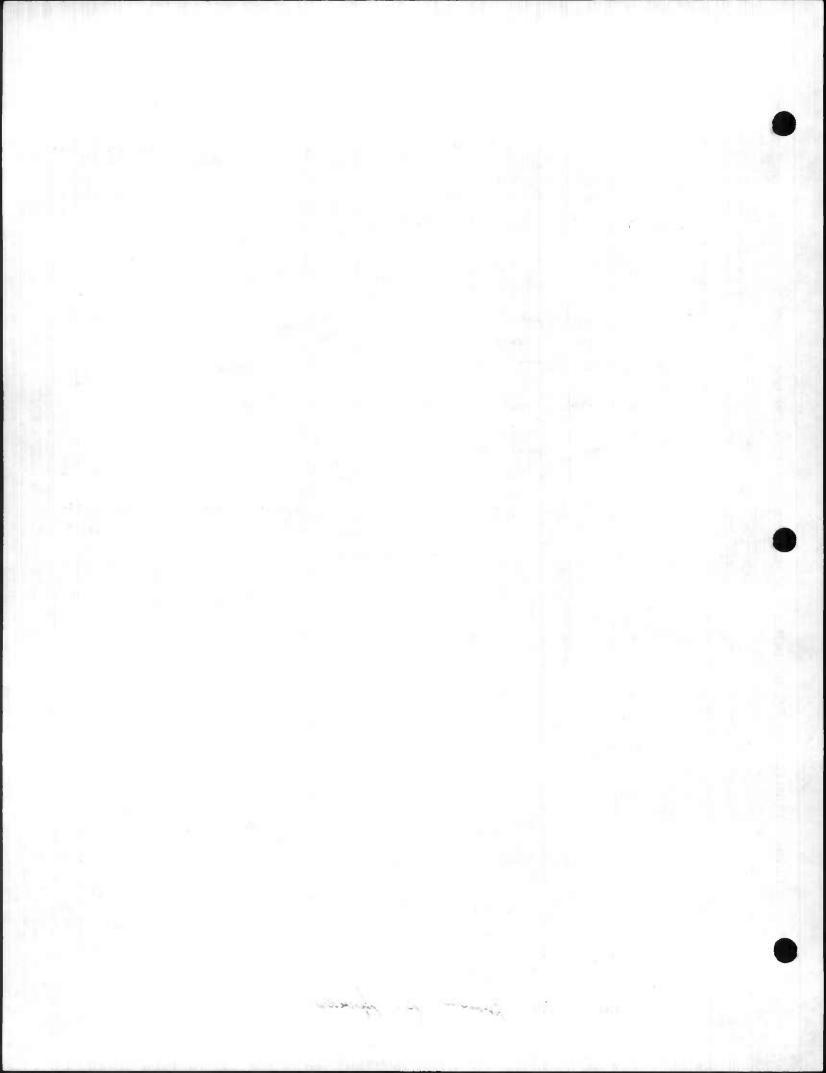
Baltimore, Maryland 21239

5601 Loch Raven Bldg.,

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sperling, M.D.



Please Type or Print In Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Forbes 27 Henry MAY 1999 1:09p 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth THE JOHNS HOPKINS HOSPITAL N/A BALTIMORE CITY | If Under 1 Yeer | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | OCT. | 104, Yeer | 54 Birthplaca (State or Foreign
 Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) 1 € M 2 □ F 218-64-4948 44 Yrs. Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Dundalk Md. 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21222 7214 Dunglen Ct. USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Race - American Indien. Bleck, White, etc. 1 R Never Married 2 Married 1 Yes 2 No Specify: White Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Construction Painter yrs. 18. Mother's Neme (First, Middle, Melden Sumeme) 17. Father's Name (First, Middle, Last) Lelia McNeal Elmer Forbes 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 7214 Dunglen Ct. Dundalk Md. 21222 Lelia Forbes mother 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State 5-29 Baltimore Oak Lawn Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Bervice Licens 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222 23a. Pen Lever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth a Disseminated Fungal Infection Immediate Cause (Finel disease or condition resulting in deeth) 1 week Due to (or as e consequence of): Acute renal failure 3 days Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last 5 years Retroviral infection Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Intravenous drug use 24b. Were autopsy findings aveileble prior to 24e. Wes an eutopsy completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Plece of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Dete of Injury (Month, Dey Yeer) 28c. Injury et Work? 1 Neturel 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES - 00 D

29d. Dete signed (Month, Day, Year)

May 27, 1999

physician end s the burial-trensit The law requires that the death certificate be executed Records, P.O. Box 68760, 89 signed by the e been si irector, page 2 s Division of Vital the Hospital or Attending Physician: nin 24 hours effer death. the Funeral Director: After this certifica npletely filled in by the funeral director, To the F within 2 To the F

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

**Funeral** 

Director

with the Maryland r 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with I Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or a shall jury or other traumatic evant, the Med cal Empirer man be nonce.

**Physician** 

/Medical

Examiner

Physician/Medical Examiner

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Completed

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Certification:

29e. Certifier (Check only one)

State Registra

31. Date filed (Month, Day, Yeer)

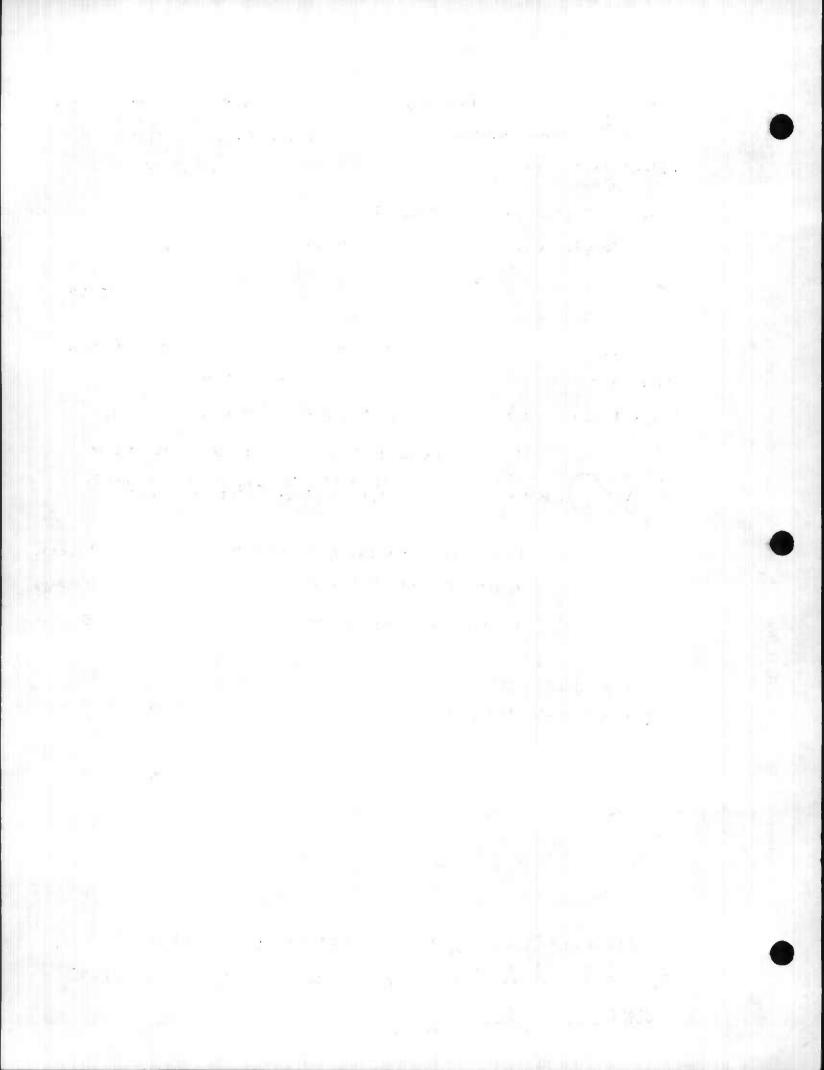
29b. Signeture and title of certifier

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)
Frances R. Jensen Johns Hopkins Hapital Baltimore, MD 21205 32. Registrar's Signeture

Francis Reuser, MD

JUN 0 1 1999

betwee & sports



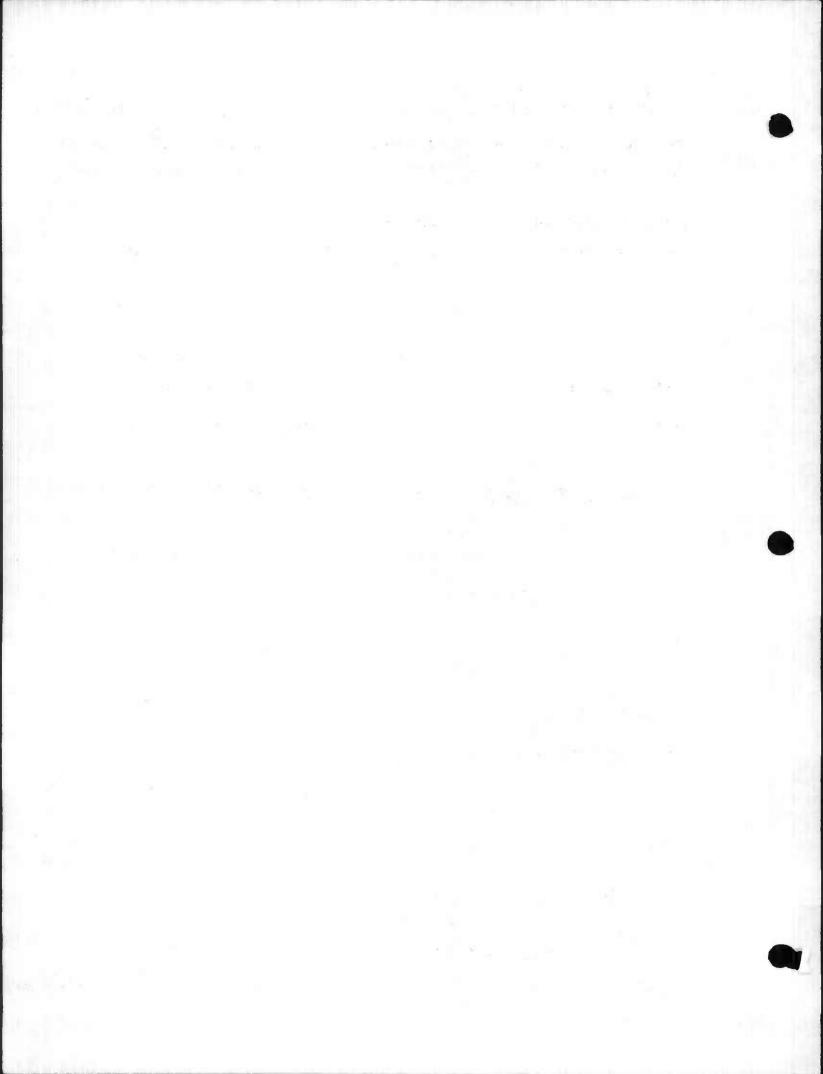
## Piease Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Dey 7:46 pm **Physician** Yeer 99 Gillespie 20 /Medical 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth VETERA Affairs Daltmon Hospital Ba Hmore Baltimon If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) If Under 1 Year 5. Social Security Number 6. Sex/ 7. Age (In yrs. last birthday) Birthpiece (State or Foreign Country) **Funeral** 10 M 20 F Months Deys 63 Director 235-50-1759 July 3, 1935 Maryland Usuei Residence of Decedent deeth with the Meryland 10e Stete 10b. County 10c. City, Town or Location 10d. inside City Limits show r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 46 Cutlass Court 21221 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 23 Yes 2 10 / 52 - Yeer or Detes: 1/56 11 Marital Status Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Reca - American Indien, Bieck, White, etc. filed withIn 72 hours efter Hyglene. 1 X Never Married 2 ☐ Merried altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: white 2 3 ☐ Widowed 4 ☐ Divorced Completed 18a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Eiementery/Secondery (0-12) College (1-4or 5+) 8 0 unknown unknown .. Pages 1 end 2 should be filed w Iment of Heelth end Mentel Hygle tant: If Item 27 is marked other ti Jury or other treumstic event, Its 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be 0 William Robert Gillispie Helen Francis Maloy 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zlp Code) 10 N. Greene St., Baltimore, MD V.A. Hospital 21201 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, State 1 ☐ Buriei 2 ☐ Cremetion 3 ☐ Removel from State parmit. Page Department of Important: If any Injury or once. 4X Donetion 5 ☐ Other (Specify) 21. Signature of Funerei Service Licansee 22. Neme end Address of Fecility Wade, Director Ronald S. State Anatomy Board, 655 W. Baltimore Street 21201 Baltimore, MD 23a Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, and the cause on each line. Approximete interval Between Onset and Deeth **Physician** /Medical Immediata Causa (Finai Myocendial Attack diseese or condition resulting in deeth) Examiner Due to (or es a consequence of): Examiner Neumonia requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest buriel-tran and Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the Due to (or es e consequenca of): SO OST attending for use es the Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? ate nes been signed by page 2 should be detact 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown 2 24b. Wera autopsy findings aveilable prior to completion of cause of death? Completed 24e. Wes an autopsy performed? 1 ☐ Yas 2 No 1 Yes 25. Wes case referred to medical examiner? Be 26. Pleca of Death (Check only one) Hospitel: 1 patient 2 ER/Outpatient 3 DOA 1 Yes 200 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 After this 27. Menner of Deeth 28c. injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Neturei 2 Accident 5 Pending investigation he Hospital or Attending in 24 hours efter deeth. he Funeral Director: Afte 1 ☐ Yes 2 ☐ No In by the 3 ☐ Suicide 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, data and piace, and dua to the ceuse(s) and manner as stated.

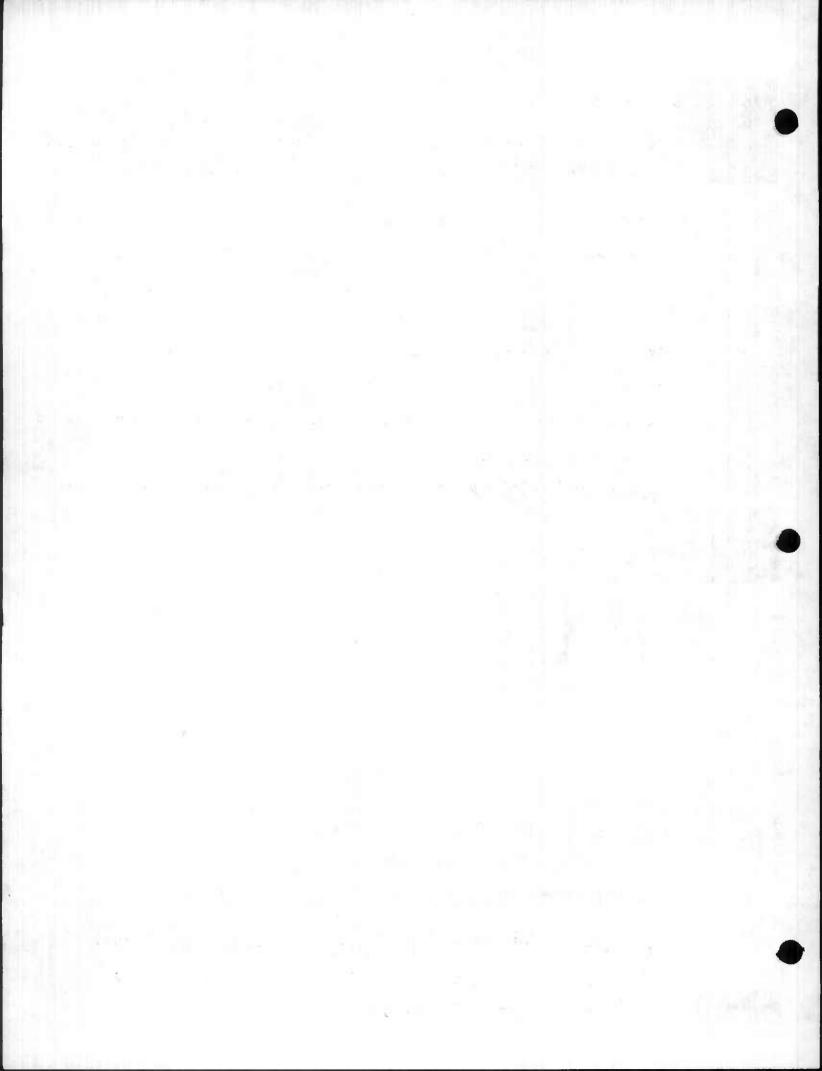
Medical Examinar: On the basis of exeminetion end/or investigation, in my opinion, daeth occurred at the tima, date and pieca, and due to the ceuse(s) end menner stated. 29e. Certifler To the Hosp within 24 hou To the Fune completely fi Medical (Check only one) 29th Signature and title of certifier 29c. License number 29d. Deta signed (Month, Day, Year) 10 30. Name end eddress of person who completed cause of deeth (itam 23a) (Type, Print) EINREICH 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State JUN 0 1 1999 Registrar



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

						-	ate of Death		Reg. No. 99	17377
	Physic		1. Decedent's Name (First, Middle, La	11				2. Date of Di	Dey /	3. Tima of Deeth
	/Medi Exami		4a. Facility Name of not institution, glv	e st/aat and number)	00	nlen	4b. City, Town, o	r Location of Dea	th 4c. County	of Deeth
	F		5. Social Sacurity Number 6. S	ex 7. Age (In yr)	C last hirth	r HO	lar 1 Year   If Undar 24 Hi	JE, ML	Dalt	imore city
L	Funeral Director			□M 2 F 7	1	Month			ber 1, 1988	Birthplace (State or Foreign Country)
	inyland ihow		10e. Stata 10b. County	10c. C	city, Town	or Location				10d. Insida City Limits
	Ba-f s	Director	Maryland	В	alti					1 ☐ Yas 2 ☐ No
	with t		10e. Straat and Numbar 6000 Bellona Ave	nue		10f. 2	Zip Code 21212	10g. Citizan of What Country? U.S.A.		
	death	Funeral	11. Maritel Status	12. Was Decadent Evar in U,S. Armad Forcas?		13. Was Dad		Specify Yas or N		e - Amarican Indien,
020	n 72 hours effer death with the Manylen "naturel", or Items 23a or 28a-f show edical Examiner must be notified at	by	1 ☐ Navar Merriad 2 ☐ Married 3 ☐ Widowad 4 ☐ Norcad			S. 13. Was Dacedent of Hispenic Origin? (Specify If Yas, specify Cuben, Maxican, Puerto Rick 1 ☐ Yas 2 ☒ No Specify:			Specify	black
Maryland 21215-0020	within ene. then	Completed	15. Decedant's Ed (Specify only highast gra Elementery/Secondary (0-12) unknown	lucetion da com <i>plated)</i> Collega (1-4or 5+) unknown		16a. Dacedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) unknown			18b. Kind of Bu	isinass/industry
פ	H the	Be Co	17. Fathar's Nama (First, Middla, Last)		uni	CIIOWII	18. Mothar's N	ame (First, Middle		a)
yla	should be nd Mental marked o	ToE	unknown				unknown			
ē,	200		19e. Intormant's Name/Ralationship (19enesis Elder Ca			19b. Mailing Addrass (Straet and Numbar or Run 6000 Bellona Avenue, B				
	He He		20a. Mathod of Disposition		Placa of D	Disposition (A	ama of	Data		21212 City or Town, Stata
im m	Pages ment of I ant: If its ury or of		1 ☐ Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 [XOther (Specify	Ramoval from Stata	Carriatary,	cramatory of	othar prace)			
Baltimore,	permit. Pages Depertment of Important: If it any injury or once.		21. Signature of Funeral Service Licen Ronald	s Wide Dire	ctor	State	end Addrass of Fecility Anatomy Boa Lmore, MD 21	ard, 655	W. Balt	imore Street
		707	23a. Part Entar the disasse, or complications that causad the daath. Do not antar the mode of dying, such as cerdiac or respiratory errest,  Approximate Interval Batween							
	Physician /Medicai		Immadiata Cause (Final disaasa or condition a. Carcinoma of				lung			Onset and Death
	Examiner		disaasa or condition rasulting in daath)			nsequenca o				6 months
	nsit	nine		b						
oʻ	certificate be executed nding physicien end use 6s the buriel-transit	edicai Examiner	Sequantially list conditions, if any, laading to Immadiata causa. Entar Underlying Cause (Disaasa or Injury	Dua to (or as a consaquence of):						
68760,	ate be hysicii the bu	dlcai	Cause Disaasa or injury that initiated evants rasulting in death) Last Dua to (or es e consaquanca of):							
9 X	certific ding p	/Me	d  Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I.							
ň	death e etten	Physician/M							40,000,000	tribute to the cause of death?
O.	es thet the death cer igned by the ettendir be detached for use									3 Probably 4 Unknown
ds,	ires th signed d be d	by								
Hecords,	been shoul	Completed						24a. Was	an autopsy ormed?	24b. Were autopsy findings eveilabla prior to complation ot cause ot daath?
2								1 🗆	Yas 2 No	1 ☐ Yes 2 ☐ No
<u> </u>	Physician: rthis certific rral director,	Be	25. Was casa retarred to medical examiner?	Hospital:			000	aath (Check only	7.0	
DIVISION OF VITAL	Phys or this oral di	n: To	27. Mannar of Deeth	1 ☐ Inpatiant 2 ☐ 28a. Dete of Injury (Month, Day Year)	ER/Outp 28b. Tin		28c. Injury at Work?	Homa 5 ☐ Rasi 28d. Dascribe	dance 8 Other	
	Attending or deeth. ector: After by the fune	edical Certification:	2 Accidant Invastigation				Work? M 1 ☐ Yas 2 ☐ No			
	2442		3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Homicida datarminad	28a. Place of Injury - At h building, etc. (Space	noma, farm	, streat, facto	ry, office	28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)		
	To the Hospital of within 24 hours early To the Funeral D completely filled in		29a. Cartifiar (Check only one) 1 ☐ Certifying Phy 2 ☐ Medical Exami	rsician: To the best of my kno inar: On the basis of axamino and mennar stated.	owledga, o etion and/o	laath occurra or Invastigatio	d et tha tima, data and plac n, in my opinion, daath occ	a, and dua to tha curred at tha tima,	cause(s) and mad data end place, a	nnar as stated. and dua to tha causa(s)
	To the comp	×	29b. Signetura end ville of certifiar	Atton Ora	Dhy	2:	9c. License numbar		29d. Data signed	(Month, Dey, Yaar)
			men.	Himail	4114	s. Com.	000536	742	May 11	1777
			30. Nema and address of person who c	omplated cause of daath (Ite)	m 23e) (T)	pe, Print)	000536 Parkway	Raltim	are N	LD
	Sta	te	31. Data tilad (Month, Day, Yaar 999	32. Aegistrar's Sign	ature 4	1		00001		



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Physician /Medical or Location of Death Examiner H Unde 24 Hrs. 7. Age (In\_yrs. last birthday) Birthplace (Stata or Foreign **Funeral** Days Months Hours 1.0 M 20 F Director Pages 1 and 2 should be filed within 72 hours aftar death with the Manyland neat of Health and Mental Hyglane. Intit If them 27 is marked other than "natural", or items 23a or 28a-f ahow intit If them 27 is marked other than "natural", or other traumatic avant, ma sendical Examinar man be notified at any or other traumatic avant, ma sendical Examinar man be notified at 10d. Inside City Limits 1 Tas 2 No Funeral Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race -Amarican Indian 11 Marital Status Black, Whita, etc. Yas 2 2 1No 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1□ Yes 2⊡ No Specify Be Completed by 3 ☑ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Giva kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Collegger (1-4or 5+) ry/Spoondary (0-12) Wher's Nama (First, Middle, Maide Father's Nama /First, Middle Last Place of Disposition (Nama of 20a. Mathod of Disposition 1 Burial 2 Cremation Department Important: I any injury o 5 Other (Specify) 4 Donation re of Funeral Service Licens 23a. Part1. If tar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiralory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Dua to (or as e consequence of) Physician/Medical Examiner attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be assouted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Dua to (or as a consequence of) been signed by the attending p should be detached for use as Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causa of death? 3 Probably 4 Unknown 1 Yaa 2 No Division of Vitai Records, Completed by 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No After this certificata funaral director, 25. Was casa referred to medical axaminer? 8 26. Place of Death (Check only ona) Other: 42 Nursing Homa 5 Rasidence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 5 Pending investigation 1 Natural death. 1 ☐ Yas 2 No 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) completely filled in by 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mennar as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, deta and place, and due to the cause(s) and mannar stated.

DHMH 16 Ray 6/95

State Registrar

30. Nama and addrass of person who complet

29b. Signature and title of certifier

29a. Certifier

d cause of death (Item 23a) (Type, Print)

CIRCLE BALOVMB21236

121022

29c. License number

29d. Data signed (Month, Day, Year)

5127/1990

P.O. Box 68760, Records, Division of Vital or Attending Physician:

Maryland 21215-0020

altimore,

eRIC

0

State

Registrar

9000 FRANKlin Square DR. BAITIMORE, MARYLAND 21237 32. Registrar's Signature 31. Date filed (Month, Dey, Year) JUN 0 1 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

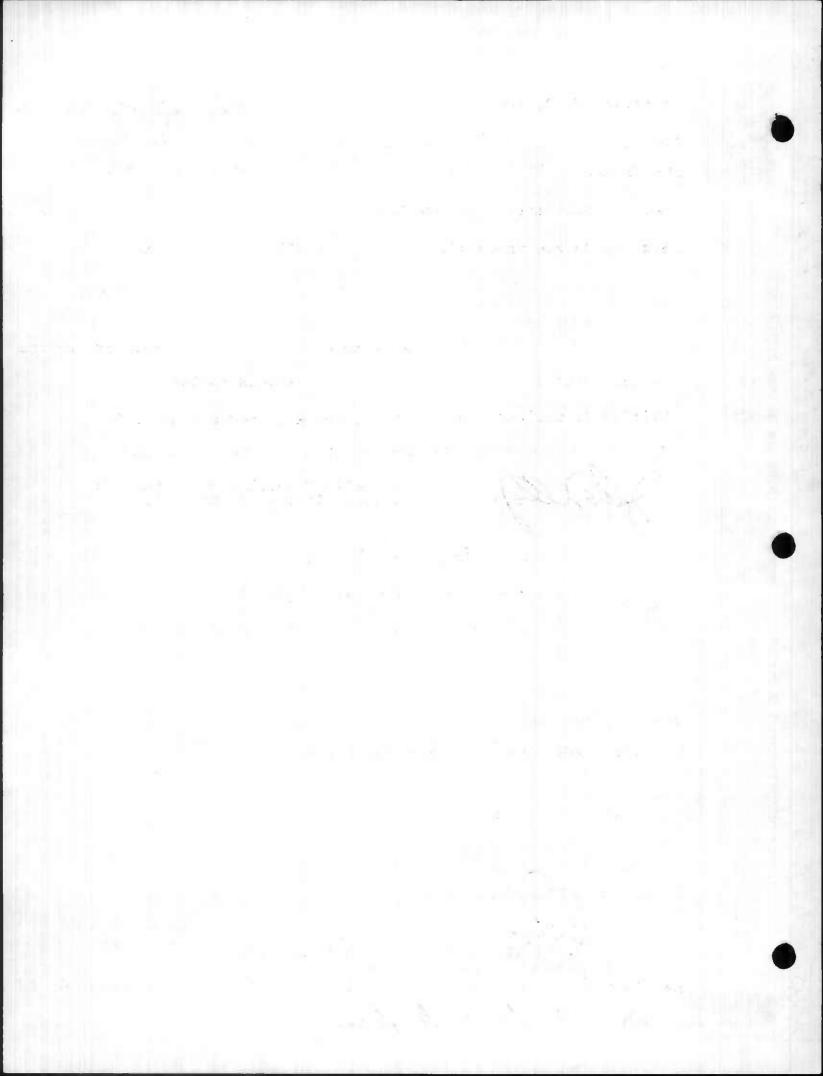
Acker MAN

Alan

alau Uchimmon Do

**DHMH 16 Rev 6/95** 

Hospital



99-2828-510

Physician /Medical

Examiner

Director

Funeral

P

MD

10e Street and Number

1 Never Married 2 Married

3 ☐ Widowed 4 ☐ Divorced

NA

3216 Westwood Avenue

LULA	
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HUGHES

		State	of Maryland / Depa					nental Hygi	ene (	0 1	7200
			Cer	tificate	of	Death		Re	g. No.	1	1300
1. Decedent's Nam	e (First, Middl	e, Last)						2. Dele of Deet			3. Time of Death
Lula	Ann	Hughes	5					Month MAY	Day	1999	8:39P.M.
4a Facility Name (	f not institution	n, give street and nu	imber)		П	4b. City, To	wn, or L	ocalion of Death	4c. C	ounty of Deat	
3216 WES	TWOOD .	AVE				BALTI	MORE	3		NA	
5. Social Security N	lumber	6. Sex	7. Age (In yrs. last birthday)	If Under 1				8. Data of Birth		9. Birt	hplece (State or Foreign
219-60-	7791	1□ M 2√2 F	44 Yrs.	Months	Days	Hours	Min.	(Month, Dey, 05-27-		N Co	C
Usual Residence of	Decedent										
10a. State	10b. County		10c. City, Town or Lo	cation							10d. Inside City Limits

10f. Zip Code

21216

1 ☐ Yes 2 ☐ No Specify:

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 XYes 2 □ No

Admin.

Approximate Interval Between Onsat and Death

24b. Wara autopsy lindings available prior to complation of causa of daeth?

1 No 2□ No

29d. Date signed (Month, Dey, Year)

MAY 17, 1999

111 Penn Street, Baltimore, Maryland 21201

10g. Citizen of What Country?

USA

16b. Kind of Business/Industry

14. Race - American Indian

Bleck, Whita, etc.

Specify: Black

Baltimore

12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes X(X)No If Yes, Give Year or Dates:

**Funeral** Director

death with the Maryland

7 is marked other than "natural", or items 23s or 28s-( show traumstic avent, the Medical Examinal must be notified at permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygiens Important; if Nem 27 is marked other than any Injury or other trauments.

e filed within 72 hours after du il hygiena. other than "natural", or Item

Baitimore, Maryland 21215-0020

Box 68760

P.O. |

Records,

Division of Vital

**Physician** /Medical Examiner

attending physician and for use as the bunal-transit The law requires that the death certificate be asscuted signed by the a page this i or Attending Patter death. After filled in by the f

Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) High Sch. Grad Clerk NA Social Security 17. Fether's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) 8 Wilma Williams Joseph Williams 19a. Informant's Name/Ratationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Wilma Williams 2820 Glenn Avenue Winston Salem, NC 27105 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State Evergreen Cemetery 06-02-99 Winston Salem, NC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Baltimore, Maryland 21202 21. Signeture of Funeral Service License nou WM.C.March FH 1101 E. North Avenue mad 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CIRRHOSIS Due to (or as e consequence of): CHRONIC ALCOHOLISM Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably WUnknown à Completed 24a. Was en autopsy performed? 1/2 Yes 2 □ No 8 25. Was case referred to medical 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To NYes 2□ No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of tnjury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) 29a Certifier

and manner stated.

32. Registrar Signature

ungo no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

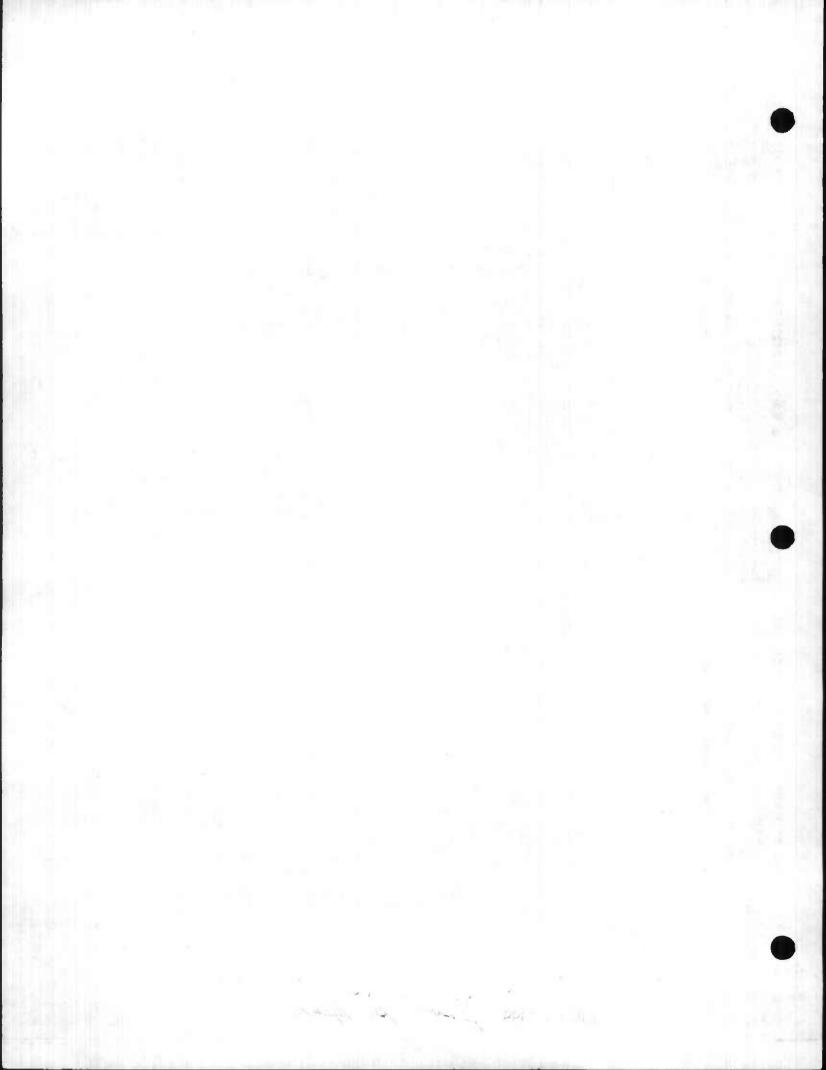
**DHMH 16 Rev 6/95** 

State Registrar

To the Hospital of within 24 hours at To the Funeral Discompletely filled in

29b. Signature

Vennis 31. Data filed (Month, Day, Year) 29c. License number O.C.M.E.



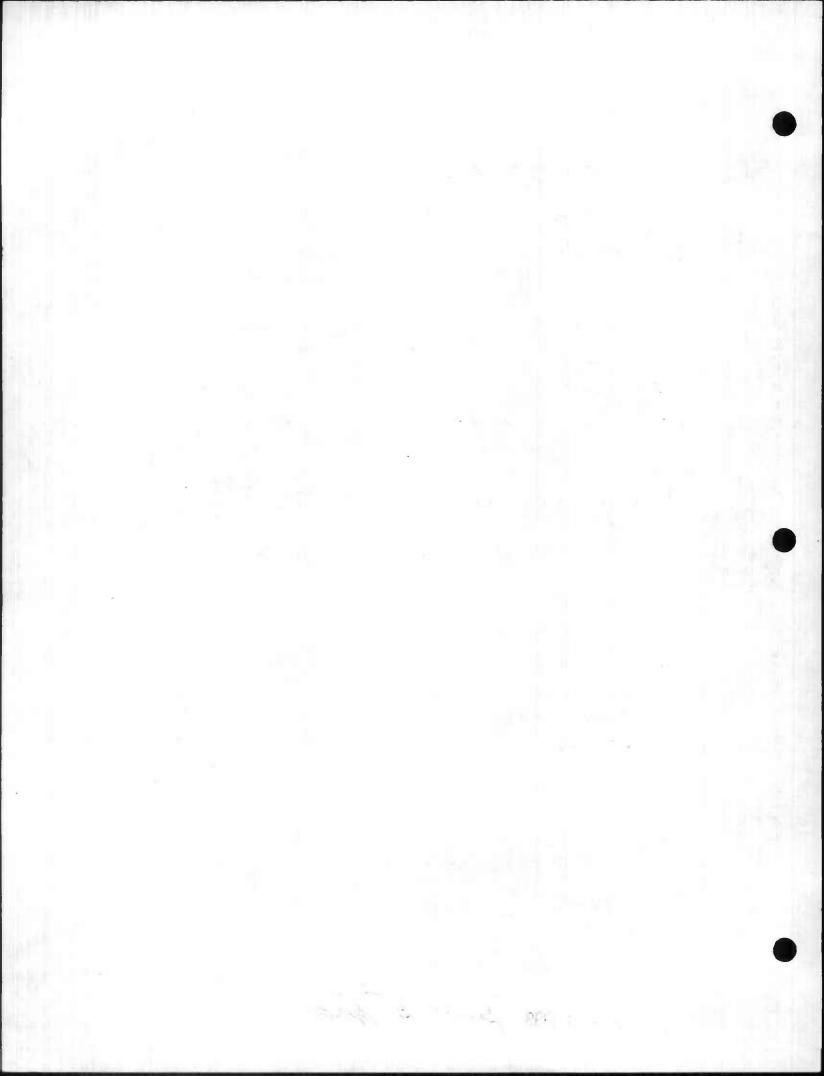
## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

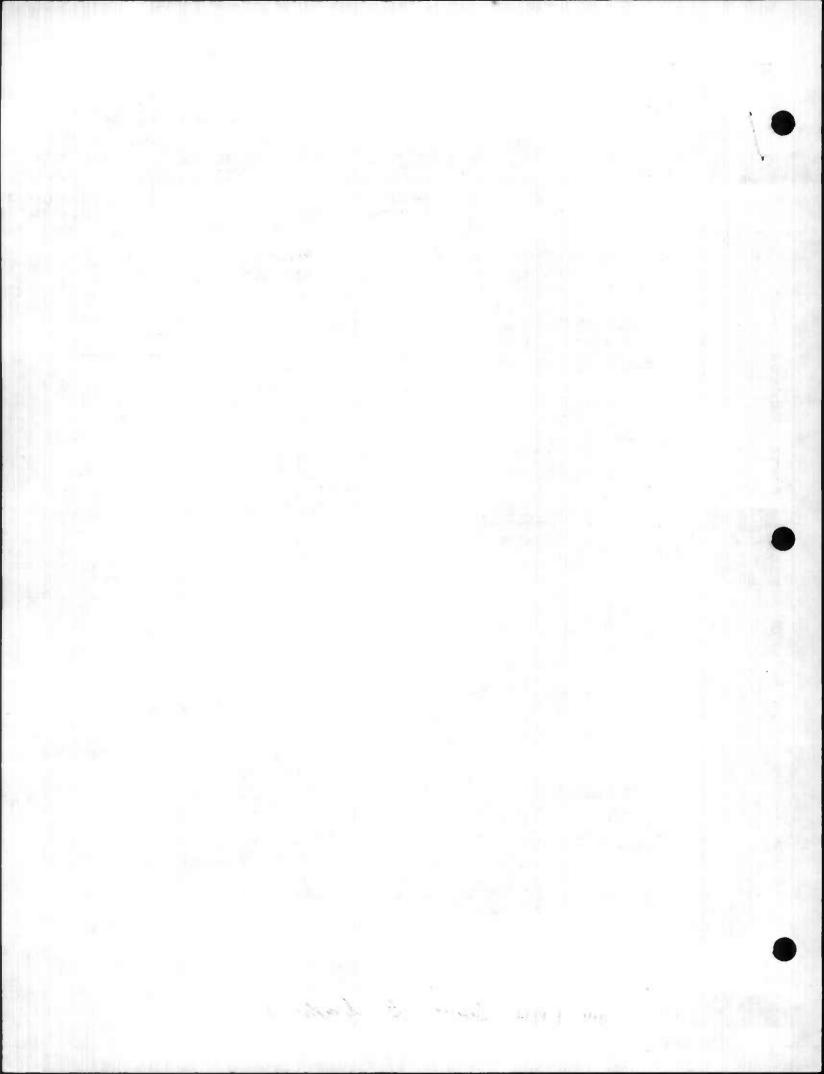
			Certificate of	f Death	Reg	. No.	17381
Physician /Medical	1. Decedent's Nama (First, Middle, Last)	PEE HAN	eris		2. Data of Death Month MAY 28	Day 199	Year 0853 AM
Examiner	Facility Nama (If not institution, give stands 3725 BELLE AVENUE	treet and number)		4b. City, Town, or I BALTIMOR		4c. County	
Funeral Director	5. Social Security Number 6. Sex	M 20 F 62	st birthday) If Under 1 Yea Months Day	r If Under 24 Hrs.	8. Data of Birth Day, Y		9. Birthplace (Stata or Foreign Country)
oseth with the Meryland ms 23e or 28s-f show creat be notified at neral Director	10a. Stata 10b. County  MARYLAND None	0	Town or Location				10d. Inside City Limits 1 A Yes 2 □ No
r flores 23e or 23s-f ehow inser must be notified at Funeral Director	10e. Street and Number	VEnue	10f. Zip Code	15		Citizen of W	/hat Country?
by i	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Cu		pecify Yes or No- o Rican, etc.)		American Indian, k, Whita, atc.  American
t, the Pealer Ex.	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		16a. Decedent's Usual Occ (Give kind of work don life, DO NOT use retir	e during most of wor	king 16	b. Kirld of Bu	siness/Industry
arked other atic event, I To Be Cc	17. Father's Nama (First, Middle, Last) EdgaR GSE			Lizzie	HAYES		
7 la m traum	19a. Interpretation Name/Relationship (Typ		19b. Mailing Address (Street	et and Number or Ru	// /		State, Zip Code) MAKY band 2 1229
int: If item 2 iry or other	20a. Mathod of Disposition  10 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	20b. Pia	ce of Disposition (Name of petery, crematory or other per	lace)	Data 20	c. Location -	City or Town, Stata  me, Maxward
important: eny injury once.	21. Signature of Funeral Service Licenses  ALLLY M.  23a. Parti. Enter the disease, or complice shock, or treat trailure. List only one	100	3405 W.		St. BAH	more	nd 21229
physician and is the buriel-transit edical Examiner	Immediata Cause (Final diseasa or condition rasulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	star Cardiavas as a consequence of): as a consequence of):	ocular D	islage		
0110	d.						
igned by the attendin be detached for use by Physiclan/N	Part II. Other significant conditions continued in Diahates m		ng in the underlying cause (	oven in Part I.		2 No	atribute to the cause of death?  3 □ Probably ✓ Unknown
s been s 2 should pieted	Dementia						24b. Ware autopsy findings available prior to completion of cause of death?  1 Yas 2 No
ector.	25. Was case refarred to medical examiner?	enite).	10		th (Check only one)		
oral dire	Yes 2 No PRO 27. Manner of Death		Proutpatient 3LI DOA		oma 5 Residen		
within 24 hours after deeth.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page  Medical Certification: To Be Com	1 Natural 5 Pending Investigation 3 Suicide 4 Homicide Could not be determined	28a. Data of Injury (Month, Day Year) 2 28a. Place of Injury - At hom building, etc. (Specify)	Injury W	Yes 2□No		et and Numb	er or Rural Route Number,
the Funeral pletely filled edical C	29a. Certifier 1 Certifying Physic (Check only one)	cian: To the best of my knowler: On the basis of examination and manner stated.	edge, death occurred at the n and/or investigation, in my	time, date and place opinion, death occu	, and due to the cau rred at the time, date	se(s) and ma e and place, a	nner as stated. and due to the cause(s)
Toth	29b. Signature and titla of certifier	Chukn	0.	.C.M.E.			(Month, Day, Year) 28 , 1999
State	30. Name and address of person wife com  Denns Ch  31. Date filed (Month, Day, Year)		1 Penn Street		ore, Maryl	land 21	.201

State Registrar



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	R F.H. #24A PER MD		9 WR.	Cer	tificate of	Death		eg. No.	
cian	Decedent's Neme (First, Mid	dle, Last)					2. Date of Deat Month	Day Y	3. Time of Death
dical	EDNA 4e Facility Neme (If not instituti	on give street and a	G number)		HERR	4b. City, Town, or		12 1999 4c. County of	6:52 AM
iner	PIKESVILLE N						VILLE		IMORE
ı	5. Sociel Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth	_	Birthplace (State or Foreign Country)
	214-24-8245	1□ M 2X) F	93	Yrs.	Months Days	TROUIS WIII.		4, 1905	MARYLAND
	Usuel Residence of Decedent  10a. Stete 10b. Coun	ty	10c. Cit	y, Town or Loc	cation				10d. Inside City Limits
Director	MD I	N/A		BALTIM	ORE				1 XYes 2 No
100	10e. Street and Number				10f. Zip Code		10	Og. Citizen of Who	it Country?
	2500 W. BELV	EDERE AVE	., APT.	309		21215		USA	
	11. Meritel Stetus	Armed	ecedent Ever in U Forcas?	,S. 13. V	Vas Decedent of H Yes, specify Cubi	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)		American Indian, White, etc.
1	1 Never Merried 2 Me 3 Widowed 4 Divorce	orried 1 Tes	S 2 No Give	1	☐ Yes 2☐ No	Specify:		Specify:	WHITE
1	15. Decede	ent's Education	THE CASE OF THE CA	16a. Deced	ent's Usuel Occup	pation		16b. Kind of Busin	
1	(Specify only high Elementery/Secondery (0-12)	est grade complete	d) (1-4or 5+)		kind of work done O NOT use retired		rking	RETAIL	
	10			PRO	PRIETOR			INSTAL	LMENT
	17. Father's Name (First, Middle	e, Last)					me (First, Middle, A		
1	ABRAHAM	askin (Time Brief)		GAINSE		KAI			RMAN
	19a. Informant's Neme/Reletion STANLEY HERR				ELVET RI		OWTNGS 1	MILLS, M	
1	20e. Method of Disposition	(501.)	20b. P	Plece of Dispos	sition (Name of			20c. Location - Ci	
	1 X Buriel 2 ☐ Cremetion 4 ☐ Donation 5 ☐ Other (		m Stete		DESH BETH		5/14/99	BALTI	MORE, MD
	21. Signeture of Funeral Service	e Licensee	- 11	22.	Neme end Addre	ss of Facility			
Medical Examiner	Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last	b		r as a consequ					
Dy Fillysicialum		d							
	Part II. Other significant condit	lona contributing to	death but not resi	ulting In the un	derlying ceuse giv	ren in Part I.			bute to the cause of death
							10 40	98 2LING 3	Probably ASUnknow
						-	24a. Was a perform		24b. Were autopsy findings available prior to completion of cause of death?
Completed							1□ Ye	15 2 🔯 No	1□Yes 2□No
2	25. Was case referred to medic examiner?				104		ath (Check only on	Θ)	
2	1 ☐ Yes 2ÊNo 27. Menner of Death		Inpatient 2	ER/Outpatient 28b. Time of	3 DOA Oth	4E-Nursing I	tome 5 Reside	nce 6 Other	
Certification:	1 Neturel 5 Pend 2 Accident Inves 3 Suicide 6 Coul	ing (Mo	onth, Day Year)	Injury	M 1	k? Yes 2 □ No			or Rural Route Number,
5	4 Homicide		lding, etc. (Specif)				City or Town	i, State)	
	29a. Certifier 1 Certify (Check only one) 1 Medica		ne best of my kno- basis of examine anner steted.	wledge, deeth tion and/or inv	occurred et the tin estigation, in my o	ne, date and place pinion, death occu	e, and due to the coursed et the time, do	ause(s) and mannate and place, and	er as stated. d due to the cause(s)
					29c. Licens	e number	2	9d. Date signed (	Month, Day, Year)
	256. Signature and title of certific				_			pn / 1 m / m	0
edical	290. Signature and title of certification of the Polyment		D		DA	+7683		5/12/9	9
Medical	30. Nama and address of person	Mullo M	use of death (Item		Print)			5/12/9	9
edical	> Paymere	Mullo M	use of death (Item					5/12/9	9



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1025 MM James Hunter Ma 28 99 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth J 4c. County of Death (-Jospita) BAITIMO F If Under 24 Hrs. 8. D Hours Min. If Under 1 Year Months Days 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 12M 20 F 213 28 5002 Oril 12,193 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Yes 2 No BARIMONE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Apt 14K

12. Was Decedent Ever in U.S.
Armed Forces?

1 Yes, 20 No
It Yes, Give
Yeer or Dates: N. Hsiquith 2/202 11514 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Maritat Status Black, White, etc. Specify: Africian 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No 3 Widowed 4) Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) tood COOK Service NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HUNIC H. 19a. tnformant's Name/Relationship (Type, Print) SON 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 835 N Regimald HUNTER BAN MULMO. 2/205 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Cremator 21. Signature of Funeral Service Licenses Albert P. WYLie 22. Name and Address of Facility Gilmor 234 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiral shock, or heart failure. List only ope ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) Metastatic Colon 2 months Due to (or as a consequence ot) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown to. lung liver, bone 24b. Were autopsy findings svailable prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 10 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Diverturei 5 Pending investigation 2 Accident

Box 68760 P.O. Division of Vital Records, To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this

**Physician** 

/Medical

**Examiner** 

Director

Funeral

à

Completed

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**Funeral** 

Director

the Meryland

permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Merylan Department of Heelih end Mentel Hyglone.
Important: If the mar /s marked other than "natural", or itema 23a or 28a-f show any Injury or other treumatic event, the Medical Exertine must be notified any Injury or other treumatic event, the Medical Exertine must be notified as

**Physician** /Medical

Examiner

attending physician and for use as the bunal-transit

Examiner

Physician/Medical

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Completed

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Certification:

edical

Baltimore, Maryland 21215-0020

25.	Was case	referred	to	medice
	axaminer?			
	1 Ves	217-No		

3 Suicide

1 Yes 2 No

281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signeture and title of certified

6 Could not be determined

29c. License number

D48120 RD 409564 29d. Date signed (Month, Day, Year) 704 28

30. Name and address of person who completed ceuse of death (ttem 23a) (Type, Print) Deleon 98

31. Date filed (Month, Day, Year)

Brocker 32. Registrar's Signature

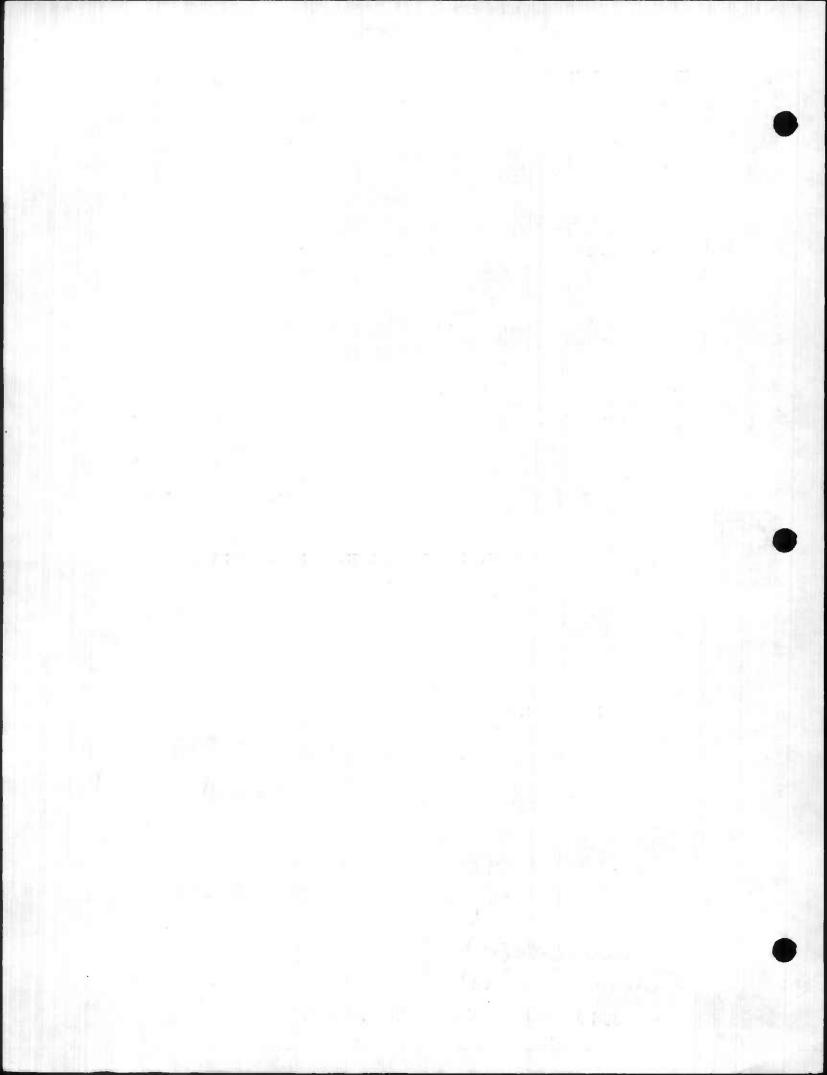
State Registrar

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0211	
Norman	Hoppenstein

		PART II PFF		5-3-99 J.A	Certificate of			g. No.	)	1384
sician	NORMAN		YOER		HOPPENSTEI		2. Date of Death Month	Dey	Year	3. Time of Death
al er		If not institution, give				4b. City, Town, or Loc	May 2 ation of Death	6, 1999 4c. County		9:58 A.M
	5. Social Security N 218-40-6	370 X <sup>0</sup>	x . 7. Ag	ge (In yrs. last birti	hday) If Under 1 Year Months Days	Baltimore   If Under 24 Hrs.     Hours   Min.	8. Dete of Birth Month, Day, DEC . 14	N, Year) 1944	9. Birthol	laca (Stete or Foreign RYLAND
- 1-	Usual Residence o 10a. State	f Decedent 10b. County		10c. City, Town	or Location				10	Od. Inside City Limits
	MD	BALTIM	ORE		BALTIMORE					1 Yas 2 No
Dy ruileiai Dilector	10e. Street and Nu	mber		1	10f. Zip Code		10	g. Citizen of V	Vhat Coun	try?
	4710 HAW	KSBURY RD			21	208		U	SA	
	11. Marital Status  1 Never Marr  3 Widowed	ied 2 Merried 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Given Year or Dates:		13. Was Decedent of H If Yes, specify Cubs  1 ☐ Yes 2 ☒ No	lispanic Origin? (Spec an, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)		a - America ck, Whita, e	
	(Spec	15. Decedent'a Educify only highest grad andary (0-12)			Decedent's Usual Occup (Give kind of work done life. DO NOT use retired SALES	during most of working	9	6b. Kind of Bu		lustry
ŀ	17. Father's Name	(First, Middle, Last)			SAUES	18. Mother's Name	(First, Middle, N			-
	ABRAHAM		5.60	HOPPEN	STEIN	REBA	1	COH	EN	
		eme/Relationship (T)			Mailing Address (Street					
-	MRS. J	AN HOPPEN	STEIN (MIE		10 HAWKSBUR  Disposition (Name of	Y RD. BAL	TIMORE,	MD Oc. Location -	21208	
	1 Burial 2 4 Donation	☐ Cremetion 3 ☐ F 5 ☐ Other (Specify)		cemeter	RAEL (MISHK	ON ISRAEL	28/99 SEC.)	BALTI		
	· A	merel Service Licens  Why  M	- Cut	the	8900 REIST		PIKE	SVILLE	, MD	21208 Approximete
	Sequentially list co if eny, leading to in cause. Enter Unde Cause (Disease or that initieted events resulting in death)	nditions, nmediate orlying injury Last	5.	Due to (or as a co					1	
	Part II. Other signif	icant conditions cor	ntributing to death b	ut not resulting in	the underlying cause giv	ren in Pert I.	23b. Did to	bacco usa co	ntributa to	the cause of death
	СН	RONIC RENAL	FAILURE				1 🗆 Ye	a 2 No	3 Prot	nebly 4 Unknow
							24a. Was ar perform	autopsy ned?	ava	ore autopsy findings allable prior to appletion of cause death?
							1 Ye	s 2 No	15	Yea 2□ No
	25. Was case refar examiner?	-	P10-1		lau	26. Place of Deeth	(Check only one	9)		
-	1. Yas 2□ 27. Manner of Deat	NO	lospitel:			4 I Nursing Hom				/)
	1 ☐ Neturat 2 ☐ Accident 3 ☐ Suicide	5 Pending investigation 6 Could not be	28a. Date of Inju		jury Wor M 1□	Yes 2 □ No	8d. Describe ho			1 Doub About to
	4 Homicide	determined	building, et	ury - At nome, far c. <i>(Specify)</i>	m, street, factory, office		City or Town	, State)	er or Hura	I Route Number,
	29a. Certifier (Check only			examinetion end	death occurred at the tir Vor Investigation, in my o					
	296. Significand	title of certifier	leger	)	29c. Licens	e number		May 27		
	-	WW U	-							
<	30. Navor and addr J. LAR 31. Date filed (Month	ess of person who co	KE, M	eath (Item 23a) ( ar's Signature		Street, B	altimor	e, Mary	/land	21201



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ITEM: #12 PER F.H. G772 6-1-99 WR. Reg. No. Certificate of Death ITEMS: #23B, 24, 25 PER G772 6-1-99 1, Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2. Dete of Death Day Month **Physician** Hitchens 1999 07:00 heodore May /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not Institution, give street end number) Examiner Bayview Medical Center Baltimore HopKins 7. Age (In yrs. lest birthday) If Under 1 Year Months Devs if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5/19/31 9. Birthplace (State or Foreign Country) Delaware 5. Social Security Number 6. Sex **Funeral** Deys **X**M 2□ F 67 Yrs. Hours 221-18-6308 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-4 show any injury or other traumatic event, or Medical Examiner must be notified an ence. 10d. Inside City Limits 10e State 10b. County 10c. City. Town or Location Laurel DE Sussex 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19956 309 Townsend St. Uniteed States Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Maritel Status Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black g 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Chrysler Auto Co Mechanic 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Alberta Waller Richard L. Hitchens 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 309 Townsend St., Laurel, DE 19956 19a. Informant's Name/Relationship (Type, Print) Ardella Hitchens/ Spouse 20b. Place of Disposition (Neme of cemetery, cremetory or other) 20a. Method of Disposition 20c. Location - City or Town, Stete or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Matthews Cemetery5/16/99 Laurel, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licansee 22. Name and Address of Facility Young's Funeral Homes, 308 N. Front St., Seaford, DE 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Do not enter the mode of dying, such as cerdiac or respiratory arrest **Physician** /Medical Immediate Ceuse (Final myocardial intarction anterior minutes disease or condition resulting In death) Examiner Due to (or es a consequence of): Examiner probable minutes Spiration pheumonia physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Sepsis Division of Vital Records, P.O. Box 68760, seudomonas Physician/Medicai Due to (or es a consequence of): days edema ulmonary esn signed by the a d be detached f Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the ceuse of death? 1 Yee 2 No 3 Probably 4 Unknown Non convulsive status epilepticus with pentobarbitalþ induced coma 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? Completed Chronic obstructive pulmonary disease with chronic is certificata has b director, page 2 s ventilator dependence via tracheostomy Severe peripheral vascular disease.
25. Wascoop referred to modical Type II Diabetes mellitus ves 1 ☐ Yes 2 ☐ No or Attending Physician: Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yea 2 No 1 ∏Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manger of Death 28b. Time of 28d. Describe how Injury occurred After 1 Netural 5 Pending investigation 1 ☐ Yea 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire completely filled in b 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the cause(s) and manner es stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(a) end menner steled. 29d. Dete signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 0 1999 MY 97012 SHEMC

Bayview Medical Center.

Baltimore

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1999

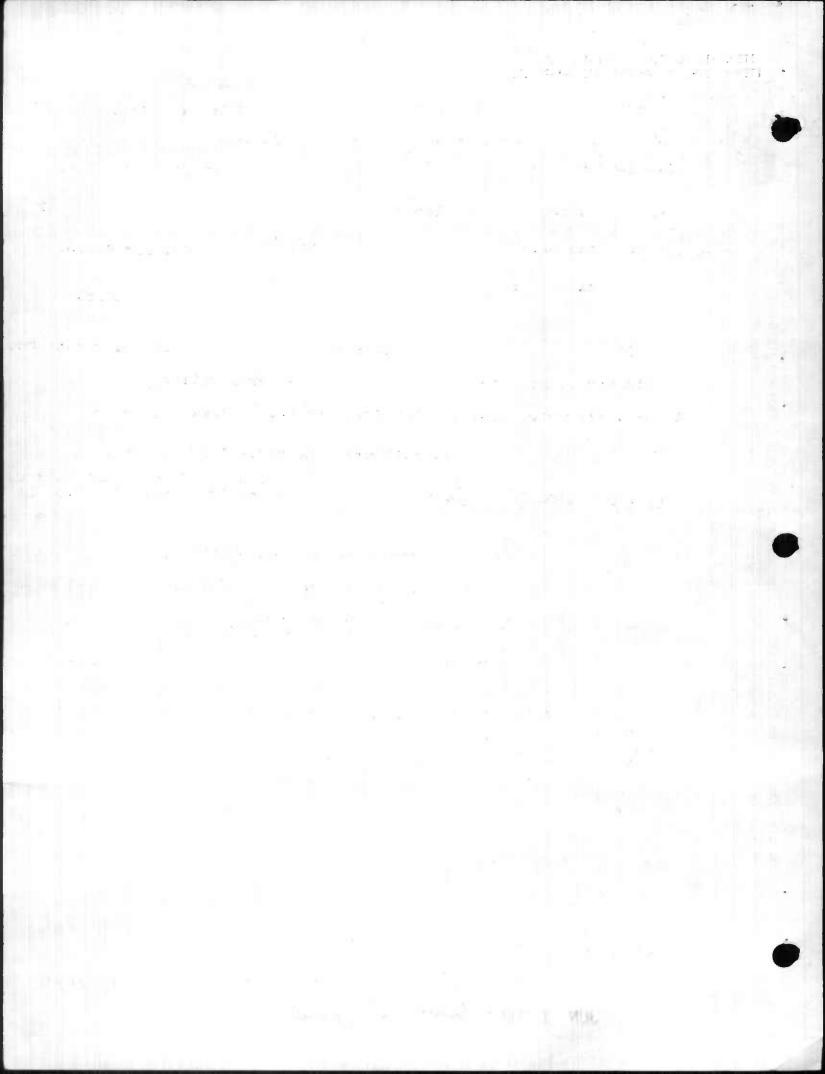
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JUN

31. Date filed (Month, Day, Year)

Johns Hopkins

32. Registrar's Signeture



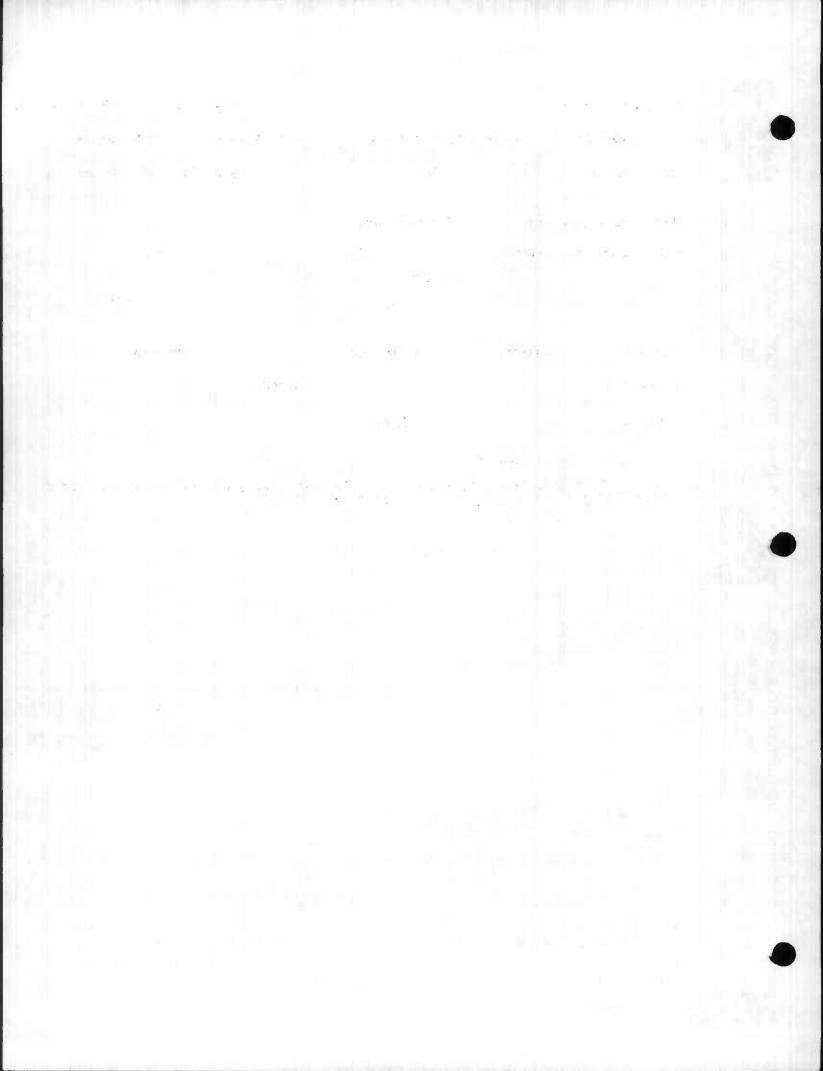
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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Birthpl	ece (Stete or Foreign
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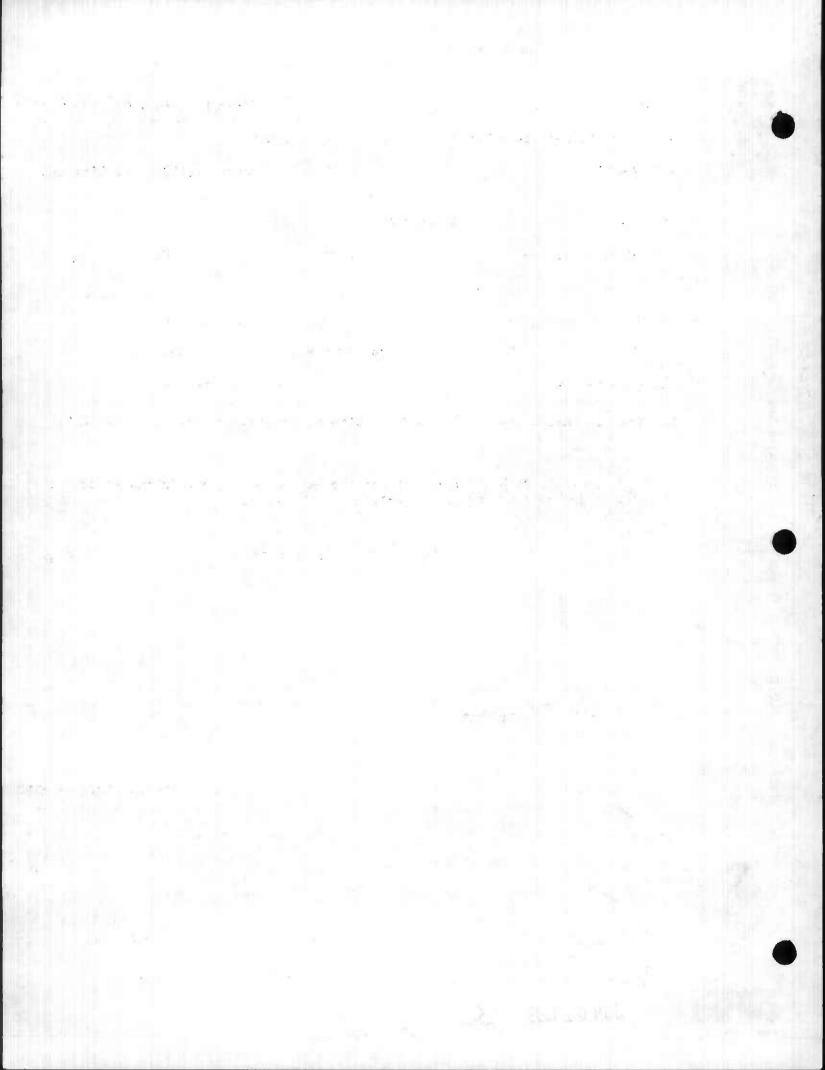
				Cerui	ilcale of i	Dealli		Reg. No.		1.90
nysician /Medical	Decedent's Name (First, Middle, L     Lilburn Jackson	ast)					2. Dete of De Month May	Dey 23	Yeer 1999	3. Time of Death 8:15 p.m
xaminer	4a Fecility Neme (If not institution, girls SHADY GROV)		ST HOS	PITA		ROCKV	ILLE	MON	of Death	ERY
ral tor	217-32-4823	Sex 7. Age	(In yrs. lest birtl		f Under 1 Year fonths Deys	If Under 24 Hrs. Hours Min.	8. Dete of Bi (Month, De March	th ay, Yeer) 1, 1935		lece (State or Foreign ltry) OWN
tor	Usuel Residence of Decedent  10e. Sfete 10b. County  Maryland Montgom	erv	10c. City, Town						1	0d. Inside City Limits
Director	10a. Street and Number				10f. Zip Code			10g. Cifizen of 1		itry?
Funeral	8321 Beechcraft		Turns in III O	40.14	20871	liananta Ostaina (Os	it- V N	U.S.	A.	an Indian
þ	11. Marifel Stetus  1 Never Married 2 Married  3 X Widowed 4 Divorced	12. Wes Decedent I Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	unknown	10	es, specify Cube	lispanic Origin? (Sp en, Mexican, Puerto Specify:	Rican, etc.)		white,	efc.
	15. Decedent's 8 (Specify only highest g		16e.	Deceden	t's Usuel Occup	efion during most of work	kina	16b. Kind of B	usiness/Inc	dustry
nanaidino.	Elementery/Secondary (0-12)	College (1-4or 5	+)	life. DO	NOT use retired	1)				
	unknown 17. Fether's Neme (First, Middle, Las	unknown	Lan	idsca	per	18. Mother's Nam	ne (First, Middle	unknowr Maiden Sumen		
	unknown	,				unknown		,	,	
	19e. informent's Name/Reletionship	(Type, Print)	19b.	Meiling /	Address (Street	and Number or Ru	ral Route Numb	er, City or Town,	State, Zip	Code)
	unknown		un	nknow	m					
	20a. Method of Disposition  1 Burial 2 Cremetion 3 Other (Special Content of Special Cont		20b. Place of cemeter)	Dispositi y, cremet	on (Neme of ory or other pled	ce)	Dete	20c. Location	City or To	own, State
	21. Signature of Foneral Service Lion Ronald	S Wade D	rector	Sta		omy Board		W. Balti	more	Street
	23a. Pet 1. Enter the diseese, or cor shock, or heart failure. List only	nplicetions thet caused y one cause on each lir	the deeth. Do n					errest,		Approximete Interval Between Onset end Deeth
	Immediate Ceuse (Final disease or condition resulting in death)	· MET	A STATIC	C	MEL	ANOMA				IYERC
	resulting in death)		Due to (or es e c	conseque	nce of):				1	
	Sequentially list conditions, if ery, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b	Due to (or es e c	conseque	nce of):					
AND 100 MAN AND 10	cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Lest	c	Due to (or es e co	onsequer	nce of):				1	
		d							i	
	Pert II. Other significant conditions	contributing to death bu	ut not resulting in	the unde	erlying cause giv	en in Pert I.		Yes 2/0 No		the cause of death?
							24a. Wes	s en autopsy omied?	ev	ere eutopsy findings elleble prior to impletion of cause death?
							10	Yes 20 No	10	Yes 2□ No
	25. Was case referred to medical examiner?					28. Place of Dee	th (Check only	one)		
2	1 ☐ Yes 2 No	Hospital: 1 Inpatie			3 DOA Oth	- Cartaiong II		Idence 8 Oth	-	(y)
Cermication:	27. Menner of Deeth  1 Naturel 2 Accident 3 Suicide 6 Could not	he	(Year) In	njury		y at k? Yes 2□No	28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route Number,			
5	4 Homicide determine	28e. Place of Inju- building, etc	c. (Specify)	m, street	, tectory, office			wn, Stete)	Der or nure	ar noute ivaniber,
edicai	29e. Cartifier 1 Certifying P (Check only one) 1 Medical Exa	hysician: To the best of miner: On the basis of end manner sta	exeminetion end	, deeth oo d/or Inves	ccurred et the tir tigation, in my o	ne, dete end plece plnion, deeth occu	, end due to the rred et the time	cause(s) and m , date and place,	anner as s end due te	tated. o the cause(s)
Σ	29b. Signeture end fifle of certifier  Chille sygn	pul, or	. 0 .		29c. Licens	mo D424	52	29d. Date signe	4, 1	
	30. Name end address of person who 18 /// // // // // // // // // // // // /	completed cause of de	eeth (Item 23e) (	Type, Pri	nt) Dr.	CHITRA 10 2085	PATA C	opac,	4.0.	2-139
ate rar	31. Dete filed (Monty VOr/)	1999 32. Registr	ar's Signature	B.	Span	h				



# Please Type or Print in Biack indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 1700

						(	Certific	ate of	Death			Reg. No.		100
		it's Name (First, Midd	dle, Last)								2. Date of De	eath Day	Voor	3. Time of Death
Physician /Madical	Cha	rles W.	Jame	es							MAY	20,	1999	7:45PM
/Medical Examiner	4a Casilina	Name (If not institution	on, give s	street and nur	nber)				4b. City, To	own, or L	ocation of Deet	h 4c. Cou	inty of Death	
		la Maris I	Hosp	ice - 1	Mercy				Balt	imor	e			
Funeral		curity Number	6. Sex		7. Age (In yr	s. lest birtho		der 1 Year	If Under		8. Date of Bir	th	9. Birth	plece (Stete or Foreign ntry)
Director	232-	26-6310	150	M 2□F	7	7 Yr	s. Mont	hs Deys	Hours	Min.	June 11			Virginia
D	Usual Resid	dence of Decedent												
ylen	10e. State	10b. Count	ly		10c. 0	City, Town o	or Location							10d. Inside City Limits
Ma Tor	Mary1	and			Ba	1timo	re							1 Ves 2 No
ith the Mai or 28=4 a be notified	10e. Street	and Number					10f.	Zip Code				10g. Citizen	of What Cou	ntry?
72 hours efter death with the Maryland natural, or thems 23a or 28a-f ahow nice Examiner must be notified at eted by Funeral Director		Eastern	Aveni	ue				2123	1			U.S	S.A.	
r tems 23s	11. Mantal	Status	1	12. Wes Dece Armed Fo	dent Ever in	U,S.	13. Was De	cedent of F	lispanic Or	igln? (Sp	ecify Yes or No Rican, etc.)		Raca - Ameri	
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by by	3 □ Wid	dowed 4 Divorca	ıd	If Yes, Giv Year or D	etes:		I L TO	2 No	Specify			Spe	ecity: whi	rce
be filed within 72 hor tel Hygiene. I other than "neturn avent, the Medical Be Completed		15. Decede				16a. D	ecedent's L Give kind of	suai Occup	ation	et of worl	dna	16b. Kind o	f Business/In	dustry
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offhe Se	17. Father's	Name (First, Middle	e, Last)						18. Moth	er's Nam	e (First, Middle	, Maiden Sun	neme)	
Mentel Mentel or street or	Ernes	t Foster	Jame	S					D	elia	Goldie	Kees		
and Meni		nant's Neme/Reletion	nship (Typ	oe, Print)		19b. N	Mailing Add	ess (Street	end Numb	er or Ru	ral Route Numb	er, City or To	wn, Stete, Zij	Code)
permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylen Department of Health and Mentel Hydiene. Department of Health and Mentel Hydiene. Important: If them 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic avant, the Madical Examiner man be notified at once.  To Be Completed by Funeral Director	Will	iam L. Jan	mes/	nephew		109	Lee	Stree	t, Ma	rtin	sburg,	W. Vir	ginia	25401
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JAMES, CHARLES



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, ITEM: 24 PER GS G772 6-1-1999 WR. Certificate of Death Reg. No. 1. Decedent's Nema (First, Middle, Last) 3. Time of Death 2. Deta of Death Day Month Year **Physician** 12:00PM ARLENE KAUFMAN MAY 1999 ¿Medical NOON 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4011 STARBROOK RD. RANDALL STOWN
If Under 24 Hrs. 8. Dete of Birth
Hours Min. (Month, Dey, Year) BALTIMORE If Under 1 Year 7. Age (In yrs. last birthday) 5. Sociel Security Number Birthplece (State or Foreign Country) Feneral Months Deys 1 □ M 2 🗓 F 214-20-2935 Director OCT 3, 1926 MARYLAND Usual Residence of Decedent the Manyland 10b. County 10c. City, Town or Location 10d. Insida City Limits show 1√ Yas 2 No Director 280-1 BALTIMORE RANDALLSTOWN 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or flams 23s or 4011 STARBROOK ROAD 21133 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 11 Marital Status 14. Race - Amarican Indian. Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Detas: 1 ☐ Never Merried 2 ☑ Merried altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiens. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Department of Health and Mental Important: If Item 27 is marked of any injury or other traumatic eve Pages 1 and 2 should be NATHAN LEE KEYSER ELSA ROSS Lo 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 4011 STARBROOK RD. RANDALLSTOWN, MD SAMUEL KAUFMAN (HUS.) 21133 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Sleta 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State KNESSETH ISRAEL ANSHE KOLK 5/13/99 BALTIMORE MD 4 Donetje 5 Dether (Specify) 22. Nema end Address of Facility SOL LEVINSON & BROS. INC. eral Service Licery 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximete Interval Between shock, or heert failure. Onset and Death **Physician** Breast Carcinoma /Medical Immediate Cause (Final 174,6 diseesa or condition resulting In deeth) Examiner Due to (or as a consequence of) Examiner physician and the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or es a consequence of): attending 980 signed by the aid P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an eutopsy parformed? Completed 2 No certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, 8 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 PResidence 8 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Menger of Deeth 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Tima of 28c. Injury et Work? 1 Natural 5 Pending investigation 1 Yes 2 No 24 hours after death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end manner es stated. Medical 29e. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner steted. To the vithin 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene Tree Rd. Suite 120 838 31. Date filed (Month, Day, Year) 32. Registrer's, Signeture State Registrar JUN

A BETT AND MEDICAL MEDICAL PROPERTY.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Tima of Death 2. Dete of Death Month **Physician** on dash (orsAIne 15.00 pm 27, 1999 ) haron May /Medical 4b. City, Town, or Location of Geath 4c. County of Deeth 4a Facility Neme (If not institution, give street and number) Examiner Union BA + more MemoriA Hours Min. 8. Dete of Birth (Month, Dey, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (Stete or Foreign Country) **Funeral** 1 M 200 F Days 21654298 Yrs. Director Maryland Usual Residence of Decedent ahow 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits mD 1 Yes 2 No Director timore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? United 2355 ton 13100 Nerns 23a 14. Race - American Indie Black, White, etc. 11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after to Department of Healin and Mertial Hygiene. Important: if item 27 is marked other than "natural; or the any injury or other traumatic avent, the factorial and 1 Never Married 21 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No If Yes, Give Year or Detes: Specify whit þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Mod House Kee 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Wilson ine 5 W-1 19e. Intorment's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Md.21227 Corrange 50 tus 0 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition, 20c. Location - City or Town, Steta Date 1 Burial 2 Cremation 3 Removal from State 6/11 netro Geneta 4 ☐ Donation 5 ☐ Other (Special) stonsville 21. Signature of Funarel Service Lie 22. Name and Address of Facility Home Su md 2(227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximele Intervel Betw **Physician** Immediete Cause (Final disease or condition resulting in deeth) /Medical 35 min Ventricular **Examiner** Examine oronary leans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last **Physician/Medical** Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Ware autopsy tindings available prior to completion of cause of death? 24a. Wes en eutopsy Yes 2 No 1 Yes 25 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica complately filled in by the funeral director, p. 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospitel: 1 Anpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Netural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be detarmined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner steted. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number mary and D41593 27,1999 -, mp leave

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Sharon

DHMH 16 Rev 6/95

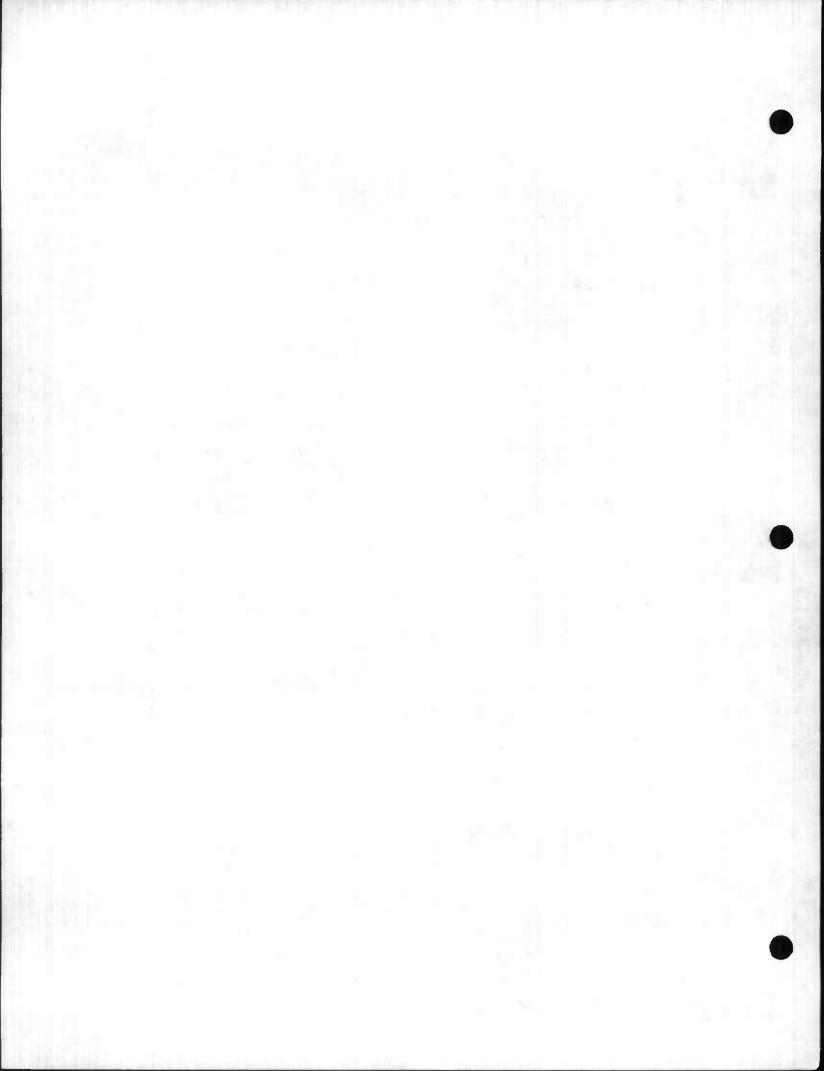
State Registrar St #650

Baltimore mo 21218

30. Nama and address of person who completed causa of death (ftem 23a) (Type, Print)

32. Registrar's Signature

Peter Sloane, Mb 3373 N. Calvert



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 300 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** MAY 1999 4:17 AM Kues, JR. Charles Raymond /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Saint Joseph Medical Center Towson Baltimore If Under 1 Yeer | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Daya Hours 1 € M 2 □ F Yrs. 74 Director 219-10-6753 May 14, 1925 Maryland Usual Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f ahow the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Baltimore Hereford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21111 USA 610 Gifford Lane Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indien, 11. Merital Status Black, White, etc. 1 Ves 2 □ No If Yes, Give 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes 2 ☑ No Specify: Aq Yeer or Detes: 1943-46 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If fem 27 is marked other than any Injury or other traument. Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ Manager Systems Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dasch 2 Charles Raymond Kues, Sr. Clara 19e. Informant'a Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 610 Gifford Lane, Hereford, MD Doris Kues/Wife 20b. Plece of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart of Jesus Cem, 6/1/99 Dundalk, Maryland 21. Signature of Fuperal Service (Conse 22. Name and Address of Facility Lemmon Funeral Home Bryan W. Clany 10 W. Padonia Road, Timonium, MD 21093 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, auch as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician CARDIOGENIC SHOCK 2 DAYS /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner ACUTE MITRAL REGURGITATION sician and burlai-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the buria ACUTE MYOCARDIAL INFARCTION P.O. Box 68760 Physician/Medical Due to (or es a consequence of) attending Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 2 No been signed by should be detac 1 Yes 3 Probably 4 Unknown ACUTE RENAL FAILURE p 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? 2 No 1 Yes No certificate Division of Vital 25. Was case referred to medicel examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1□ Yes 2 No P Impatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 5 Pending investigation death. 1 Yea 2 No 2 Accident or Attend efter death Director: 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, atreet, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) á 4 Homicide Hospital 24 hours 9 24 hours 29a, Certifler (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. Medical To the Hosp within 24 hos To the Fune completely fi 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-30263 5-30-99

OH AT

DHMH 16 Ray 6/95

State

Registrar

7620 YORK ROAD, TOWSON, MARYLAND 21204

oaks

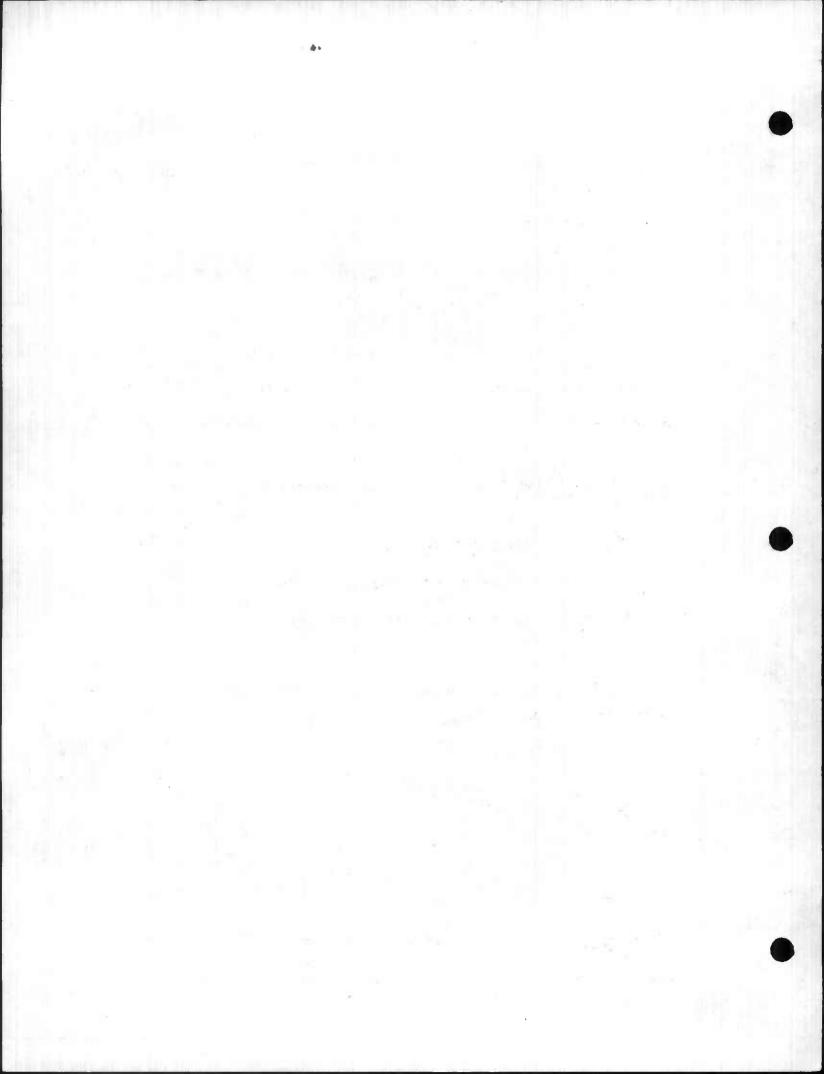
30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print)

32 Aggistrar's Signature

M. D. ,

FRANCIS KHOO,

31. Date filed (APANDO: Year) 999



## Please Type or Print In Black indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene ITEMS: #1. 23PART II PER MEO G772 6-1-99 WR. Certificate of Death Reg. No 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month **Physician** JENNIE KEITH Phule /Medical 4a Fscility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Baltimore Johns Hopkins Bayview Medical Center 8. Dele of Birth (Month, Dey, Year)
Nov. 17, 1914

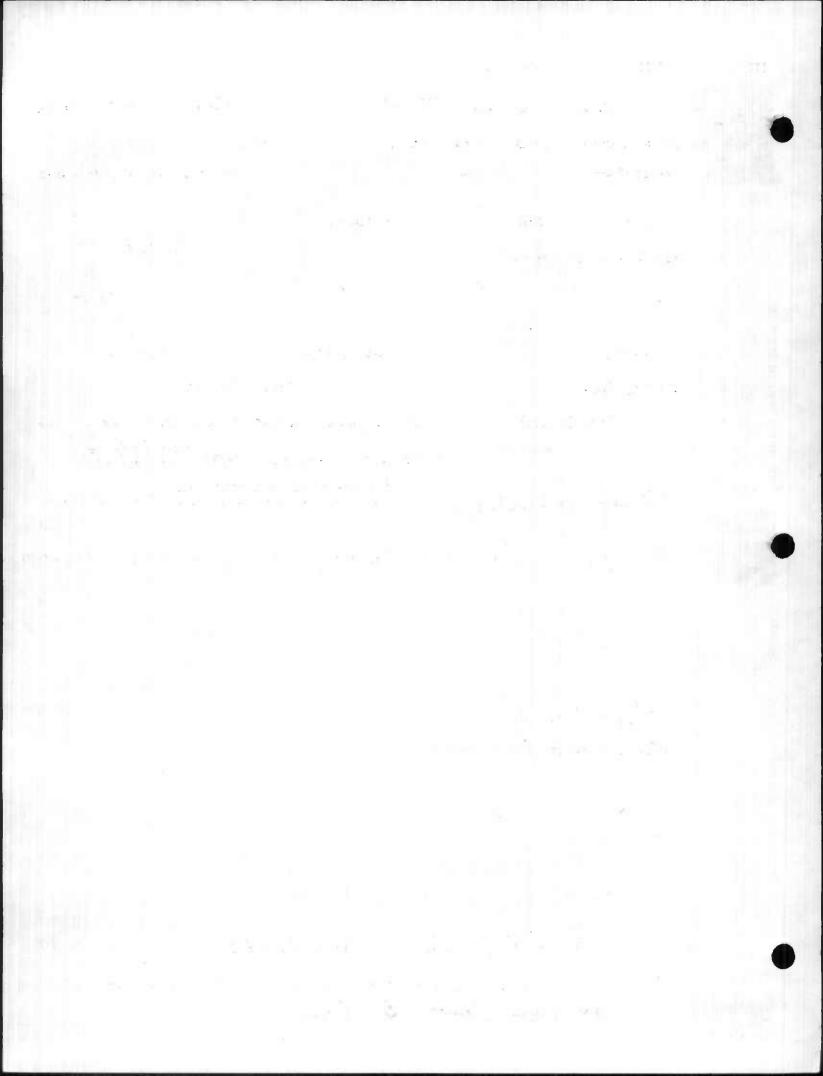
Pennsylvania 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year if Under 24 Hrs. Birthplece (State or Foreign Country) **Funeral** Deys 1 □ M 200 F Hours Months Director 178-05-3363 84 Usual Residence of Decedent 10e. Stete 10d. Inside City Limits 10b County 10c. City. Town or Location 7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Medical Examiner mant be notified at 1 N Yes 2 □ No Directo Maryland N/A Baltimore 10g. Citizen of Whel Country? 10e. Street and Number 10f. Zip Code U. S. A. 812 N. Linwood Avenue 21205 Funeral deeth 12. Wes Decedent Ever In U,S. Armed Forces?

1 Yes 2 No if Yes, Give Yeer or Detes: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 11. Merifei Stelus permit. Peges 1 and 2 should be filled within 72 hours effer c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or item any injury or other traumatic event, the Magical Exercises PROB. Bleck, White, etc. 1 Never Married 2 Married 1□ Yes 2No altimore, Maryland 21215-0020 Specify: Specify: White. by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Clothing Elementery/Secondary (0-12) College (1-4or 5+) Seamstress Factoru 3rd Grade 17. Fsther's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumame) Stanley Idep Unknown Anna 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Joan T. Elmo (Niece) 812 N. Linwood Avenue, Baltimore, Maryland 21205 20b. Plece of Disposition (Neme of cemetery, cremetery or other plece) 20e. Method of Disposition Dele 20c. Location - City or Town, Stete Coal Township. 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Stanislaud Cemetery 5/19/99 Pennsylvania 22. Name end Address of Fecility 21. Signeture of Funerel Service Licensee Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213 23e. Pert1. Enter the diseese, or complice shock, or heert feilure. List only one the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final pulmonary disease disease or condition resulting in deeth) **Examiner** Examiner physicien end s the buriel-trans Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disesse or Injury that initiated events resulting in death) Lesf Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es s consequence of) 98 esn Po signed by the end to be detached for Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the causs of death? 1 Yes 2 No 3 □ Probably 4 Unknown by 24b. Were sutopsy findings svelleble prior to completion of cause of deeth? 24e. Wes an eulopsy Completed page 2 2 X No 1 ☐ Yes 2 No 1 ☐ Yes certificate To the Hospital or Attending Physicien: within 24 hours effer death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Wes cese referred to medical exeminer? Be 28. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpetient 3 DOA 2 1 Inpafient 28c. Injury et Work? 28d. Describe how injury occurred 27. Menner of Deetl 28b. Time of Certification: 5 Pending Investigation 1 Waturel Injury 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Sulcide 6 Could not be determined 28e. Plece of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the csuse(s) end manner as steted.

2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, and due to the cause(s) end menner steted. edical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of confifier D0052583 30. Name end eddress of person who completed dause of deeth (Item 23e) (Type, Print) ravid Naiman Johns Hopkins Bayview Med. Ctr. 4940 Eastern Ave. Balto, Md 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State 1 1999 JUN

Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Dete of Deeth Month **Physician** JEOVALJ. LOWIS /Medical 4b. City, Town, or Location of Deeth 4e. Fecility Name (If not institution, give street end number) c. County of Deeth **Examiner** Balto atonsville 5. Sociel Security Number 219 38 8 46 1 If Under 24 Hrs. 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Deys Director Mary land Usuel Residence of Decedent 10e Stete 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner naul be notified at BAltimore 1 ☐ Yes 2 No Director tons ville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ŏ permit. Pages 1 and 2 should be filled within 72 hours after death w. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a c any lighty or other traumatic event, tre 1023 hoice Lake Funeral 12. Was Decedent Ever in U,S. Amed Forces? 1 (127 es 2 | No If Yes, Give Year or Dates: 19 (6 c - 1972) Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stetus 1 Never Married 2 Married Specify: White 1 Yes 2 No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) AGE 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Lewis. VAVId CASPER Elizabeth 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 1 Kridge MD. 2106 G-100,4 20b. Piece of Disposition (Neme of cemetery, cremetory or other to 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Louden 4 Donation 5 Other (Specify) 21. Signeture of Funerel Service Licenseel 323 Sulphur Spring Rd. md. 2122 uneral H some 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. **Physician** immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest the bunial-tran Due to (or es a consequence of): Due to (or as a consequenca of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? signed by t 22500 3 Probably 4 Unknown Completed by ate has been sig pege 2 should b 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy this certificate has 2 2 No. 1 ☐ Yes 1 ☐ Yes 2 ☐ No Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this certifica stely filled in by the funeral director, s 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 5 Residence 6 Other (Specify) 200 No Certification: To 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 5 Pending Investigation 1 Neturel 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide

Division of Vital To the Hosp within 24 hou To the Fune completely fi

The law requires that the death certificate be executed

Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

State Registrar

Medical

29a. Certifier

31. Dete filed (Month, Day, Yeer) JUN 0 1 1999

29b. Signature and title of certifie

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

32. Registrer's Signature

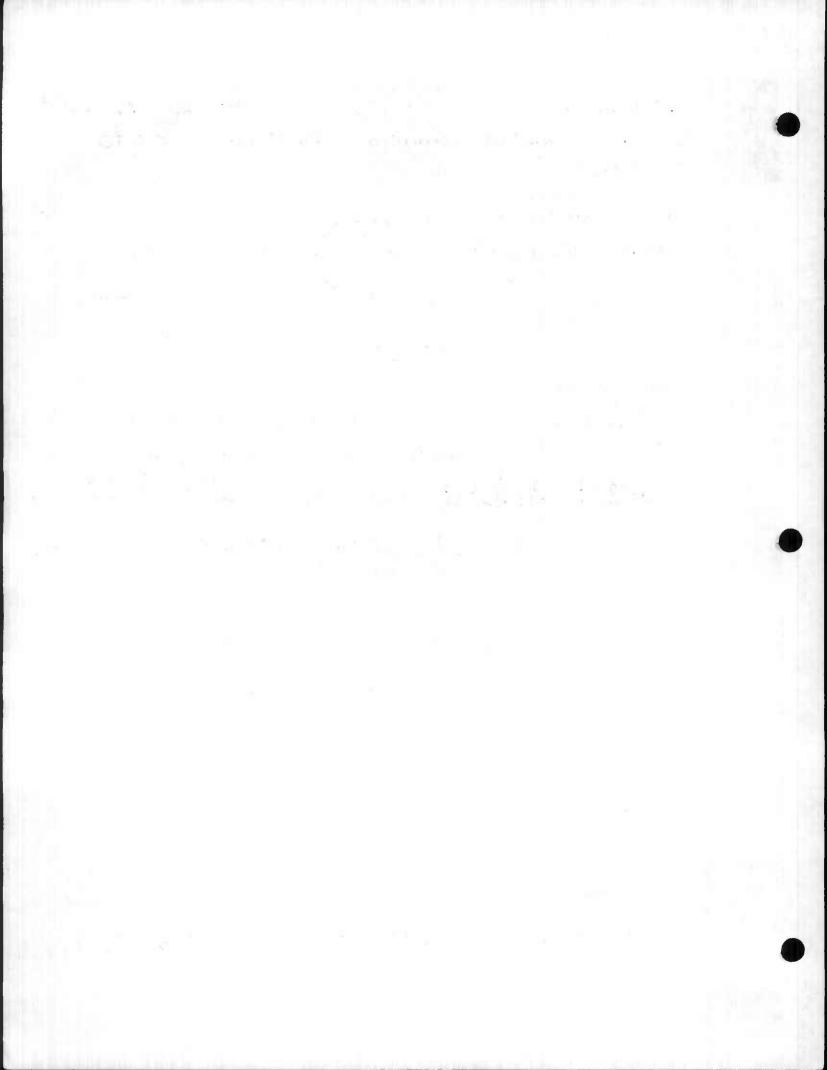
Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the besis of examination end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner steted.

29c. License number

29d. Date signed (Month, Dey, Year)

DHMH 16 Ray 6/95



## Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🛛 🔘 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Mayonth **Physician** 29ay 1999ar 9:25am Margaret Alice Leuschner /Medical 4a. Facility Name (If not institution, give street and number)
Maryland Masonic Homes 4b. City, Town, or Location of Death 4c. County of Death Examiner Cockeysville Baltimore If Under 1 Yaer If Under 24 Hrs.
Months Deys Hours Min. 8. Deta of Birth (Month, Pay 300) 6/3/1904 5. Sociel Security Number 7. Age (In yrs. last birthdey) Birthplaca (Stete or Foreign Country) **Funeral** 1□M 2X F 217-36-3282 Yrs Director 94 Maryland Usuel Residence of Decedent with the Maryland 10a. Stete 10c. City, Town or Location 10d. Inside City Limits Hem 27 is marked other than "natural", or items 23s or 28s-f show other traumetic event, the Modical Examiner must be notified at 1 Yes 2 No Director Baltimore Cockeysville 10a. Street and Number 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after deeth v Department of Health and Mental Hygiene, important: if Item 27 is marked other than "natural", or Items 23a any Injury or other traumatic event, the Medical Experience 2008. 300 International Circle 21093 Funeral USA 12. Was Decedant Evar In U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bieck, White, etc. 1 ☐ Never Merried 2 ☐ Merried Saltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: White þ 3Ã Widowed 4 □ Divorced 18e. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Coilega (1-4or 5+) N/A Elementary/Secondery (0-12) Housewife Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumema) Keller David Leather Gertrude Elizabeth Meyers 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code) Margaret A. Sewell/Daughter 923 Rosalie Way Salisbury, MD 21804 20a. Method of Disposition

↑□ Burial 2 □ Cremetion 3 □ Removel from Stete 20b. Piece of Disposition (Nema of cemetery, cremetory or other plece) 20c. Location - City or Town, State Deta June 1, Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Neme end Addrass of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Road Timonium, MD 21093 Michael J. Magle 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter tha mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** End Stage Denertin /Medical Immediate Ceuse (Final disease or condition resulting In deeth) Examiner Due to (or as a consequence of): One to (or as a consequence of): Cerebal Vas culen Diflere Examiner physician end the burial-transit The law requires that the deeth certificate be axecuted Sequentially list conditions, if any, leeding to immediate cause. Enter Undarlying Cause (Disease or Injury Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es a consequence of): thet Initieted events rasulting In death) Lest 9SM for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Dialettus, Hyperterson 1 Yes 2 No 3 Probably 4 Unknown by 24b. Ware autopsy findings available prior to completion of cause of death? 24e. Was an autopsy Completed certificate hes 1 Yas 25 No 1 Yes 2 No funeral director, 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) 8 Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No this 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Meturei il or Attending after death. Director: After 1 Yes 2 No 2 Accident 6 Could not be determined To the Hospital or Atte within 24 hours after de To the Funeral Directo completaly filled in by the 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Steta) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29e. Certifier 1 Contifying Physician: To the best of my knowledge, deeth occurred et the time, dete and piece, end due to the ceuse(s) and manner as steted. Medical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and mennar steted. 29d. Date signed (Month, Day, Year) heurs, us 30. Name and address of person who completed cause of deeth (item 23e) (Type, Print)

BALTO, med 21224

AH3

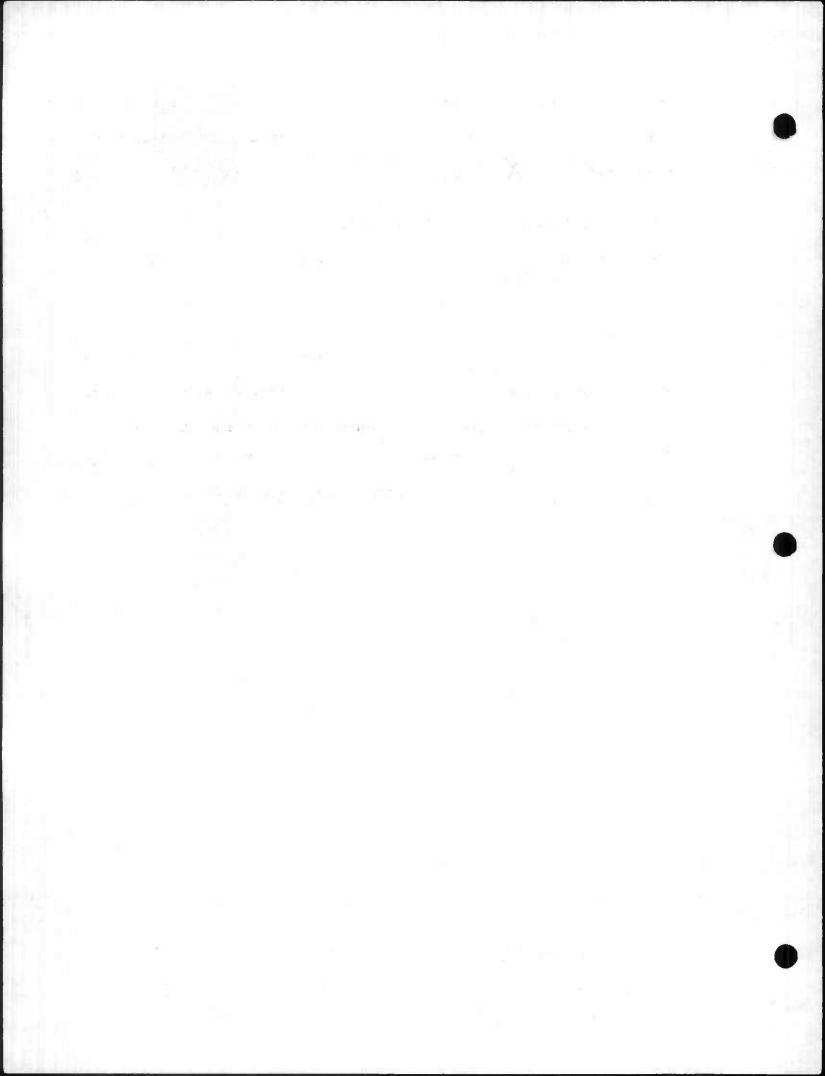
DHMH 16 Rev 6/95

State Registrar ROBERT LIBERTO, MD

8015

32. Registrer's Signatura

BANK ST



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death 11.20 Am Month **Physician** 1999 May John C. 20 Leitch /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Agnes Health Care Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 1 XM 2 ☐ F 91 Yrs. 214-01-4037 Sept.16,1907 Director Maryland Usual Residence of Decedent 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Item 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Medical Evans or must be notified at tyE Yas 2 □ No Maryland Baltimore Direct the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 427 Drudy Lane 21229 U.S.A. Funeral death 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status 12 should be filed within 72 hours effer on and Mental Hygiene. 1 ☐ Yas 2 XNo It Yas, Giva Yaar or Datas: 1 ☐ Nevar Married 2 ☑ Married Saltimore, Maryland 21215-0020 1 ☐ Yas 2 X No Specify: Specify: white p 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highest grade complated) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) 14 Salesman Brushes 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) John Frank Leitch Lillian Evans Bredemeyer 19a. informant's Name/Raletlonship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) permit. Peges 1 and 2 st Department of Health end Important: If Item 27 is n any injury or other traun pncs. Anne H. Leitch/wife 427 Drudy Lane, Baltimore, MD 21229 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval trom Stata 4 X Donation 5 ☐ Othar (Specify) 21. Signatura of Fynarai Sarvice Licensaa 22. Nama and Addrass of Facility Ronald S Wade Director State Anatomy Board, Baltimore, MD 21201 655 W. Baltimore Street 23a. Part. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Intarval Batween Onsat and Death **Physician** /Medical Immediata Causa (Final disaasa or condition resulting in daath) Congestive Examiner Examiner physician and the buriel-trans Sequentially list conditions, if any, laading to Immadiata causa. Entar Undarlying Ceuse (Disease or Injury that initieted avents rasulting in daath) Last Dua to (or as a consequence of): insu Physician/Medicai Dua to (or as a consequenca of): 88 arlens 0SD o 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Tos 2 No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Wara autopsy tindings available prior to 24e. Wes en eutopsy performed? completion of causa of death? hes 1 Yas 2 No 1 Yas 2 No 25. Was case referred to medicel axaminar? Be 26. Pleca of Deeth (Chack only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 10 funeral 27. Mannes of Death 28b. Time of 28d. Dascribe how injury occurred Certification: 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Naturel 5 Panding 1 Yas 2 No Invastigation 2 ☐ Accident efter death Director: 6 Could not be datamined 3 ☐ Sulcida 28t. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, tarm, street, factory, office building, atc. (Specify) 4 Homicide 24 hours 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, and dua to the cause(s) and menner as stated.

2 Medical Examinar: On the basis of axeminetion end/or investigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s) end mannar stated. edicai 29a. Cartifiar To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signatura and titla of cartiflar 29c. Licansa number 29d. Data signed (Month, Day, Year) M.D. 20,

State Registrar

31. Data filed (Month, Day, Year) JUN 0 1 1999

Mustapha

Mallah 4.1). 32. Ragistrar's Signetura

30. Nama and addrass of person who completed cause of death (Item 23e) (Type, Print) 900 Carron

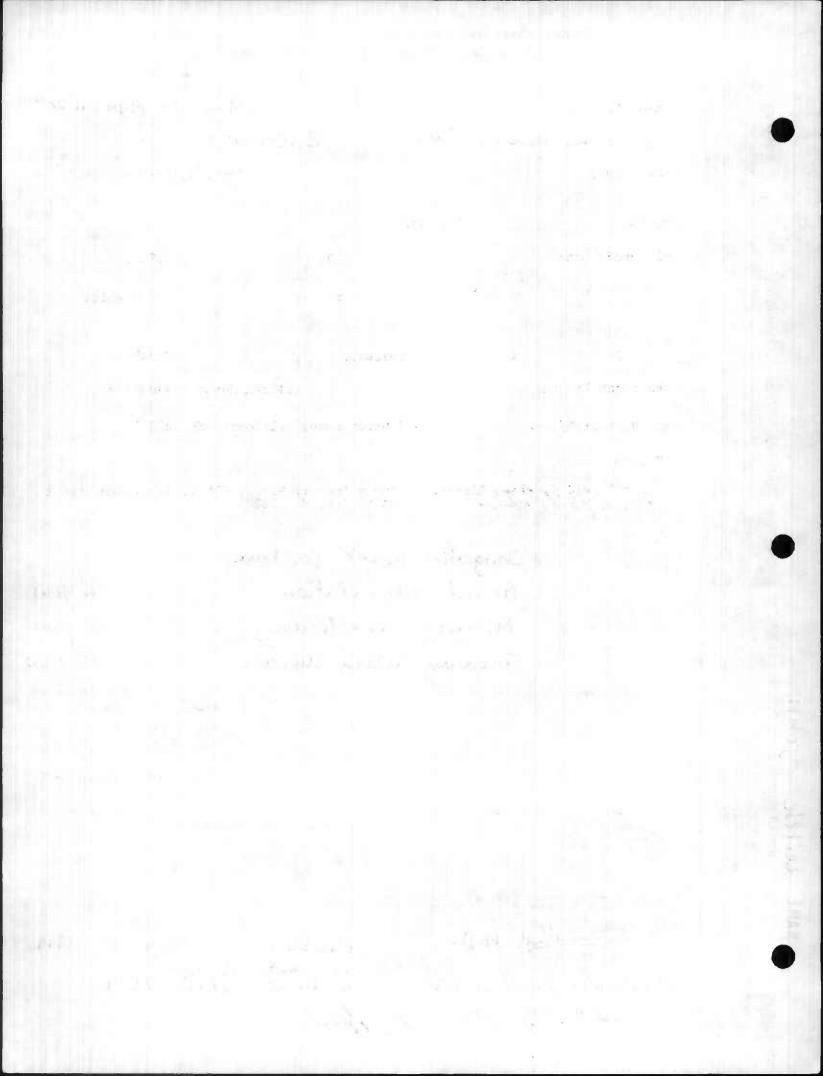
Baltimore

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Deeth Month 28ª **Physician** 1999 7:32 pm WILLIAM J. /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Neme (If not institution, give street end number) Examiner FRANKLIN SQUARE HOSPITAL BALTIMORE ROSEDALE If Undar 1 Year If Under 24 Hrs. Hours Min. Birthplaca (Stata or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dey, Year) **Funeral** 1⊠M 2□ F Months Deys Yrs. 79 Director APRIL 24 1920 MARYLAND 212 14 0021 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, tre Medical Express; must be notified at 1 Yes ZENo BALTIMORE ROSEDALE Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21237 USA 1204 NARCISSUS AVENUE Funeral 12. Wes Decedent Evar in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Yaar or Detes: WW I 14. Reca - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of mant of Health and Mental Hygiene.
ant: If Item 27 ie marked other than "naturel", or item ury or other traumatic event, the Manical Expension 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: WHITE WII by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) College (1-4or 5+) Elementary/Secondary (0-12) MACHINIST COPPER CO. 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Nema (First, Middle, Last) Be LUTTER **JOHANNA** UNK. UNK. 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) BALTIMORE, MD 21237 1204 NARCISSUS AVE MARIE A. LUTTER / WIFE 20b. Plece of Disposition (Name of cametery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Buriel 2 ☐ Crametion 3 ☐ Removel from Stata permit. Page Department of Important: If any Injury or once. 5/31/99 BALTIMORE, MD 4 ☐ Donetion 5 ☐ Other (Specify) BOHEMIAN NATIONAL 21. Signeture of Funerel Service Communication <sup>22</sup> Name and Address of Facility FUNERAL HOME 1211 CHESACO AVENUE BALTO, MD 21237 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** tmmedlete Ceuse (Finel disease or condition resulting In death) /Medical Examiner 10 years Examiner disease physician and the bunal-transit Sequentielly list conditions, if any, leading to Immadiete cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest a consequenca of) Division of Vital Records, P.O. Box 68760, requires that the death certificate be Physician/Medical Due to (or es e consequenca of): as esn signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 Yes 2 No þ 24b. Were autopsy findings available prior to Completed 24e. Wes en eutopsy performed? completion of cause of deeth? paga 2 s has 1 ☐ Yes 2 ☐ No 1 Yes certificate or Attending Physician: funeral director, 25. Wes case referred to medical Be 26. Plece of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 2 ER/Outpatient 3 DOA 1 Inpatient After this 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Neturel 5 Pending death. 1 ☐ Yes 2 □ No investigation 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 Sulcide 28a. Place of Injury - At homa, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) filled in by 4 ☐ Homlcide Certifying Physician: To the best of my knowledga, daath occurred at tha time, dete and pleca, end due to the causa(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pleca, and due to the cause(s) and menner stated. 29e. Certifier edical To the Hosp within 24 hor To the Fune completaly fi (Check only one) 29c. Licensa number 29d. Dete signed (Month, Dey, Year) 29b. Signature and title of certifier D07632 M.D. J. Crottan Ottonovan,

State

V. CROSS AN

31. Dete filed (Month, Dey, Year)

JUN

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

O DONOVAN

m.D

32. Registrer Signature

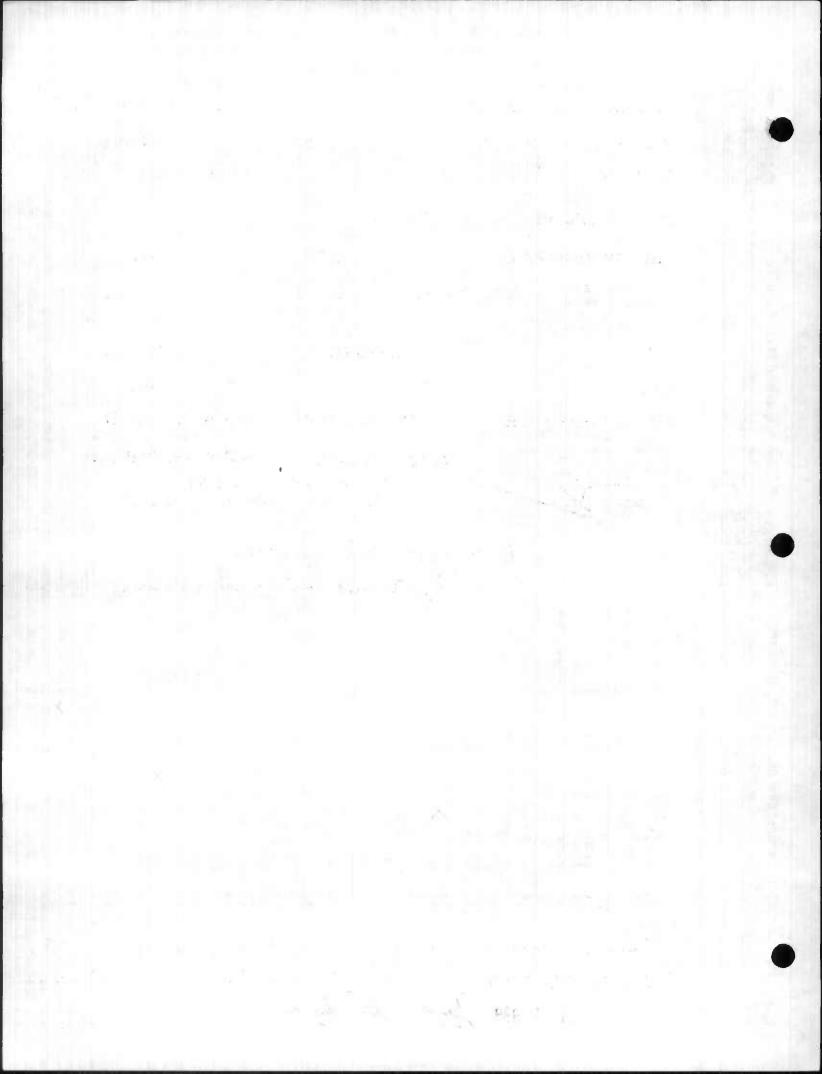
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Registrar

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#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yes 98 , 1999 Mar 27 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore Nursin a Home ono (green tf Under 24 Hrs. 8. Date of Birth If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) XXM 2DF Months Days Yrs 543-36-4159 64 July 9, Montana Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√Yes 2□No Maryland N/A Baltimore 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 4100 North Charles Street 21218 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 (A) No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 1 Never Married 2 Married 1□Yes 2XXVo Specify 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) U.S.Government Economist 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Lundena Olsen Marion Wayne Lash 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary J. Lash Wife 4100 North Charles Street Baltimore, Maryland 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🕅 remation 3 ☐ Removal from State 5/28/99 Baltimore, Maryland 4 ☐ Conation 5 ☐ Other (Specify) Greenmount Cemetery 12. Name and Address of Facility re of Funeral Service L Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 unus Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) Encephalopathy iveels Cimhosis 404 Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initieted events ubstunce abuse that initieted events resulting in death) Last Due to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 YSS 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? Were autopsy findings available prior to completion of cause of death? 2 No 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Hospital: 1 Inpatient Other: 4 Sursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 5 Pending Investigation 1. Natural 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide PErcertifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner as stated. 2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner steled. 29a. Certifier

the death certificate be executed the buriel-transit physician and Box 68760 80 P.O. the signed by t The law requires thet Division of Vital Records, peen hes certificate or Attending Physician: this luneral n 24 hours after death.

Ne Funeral Director: After the pletely filled in by the funeral Hospital pletely within 2 0

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

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permit. Peges 1 and 2 should be filed within 72 hours efter death 1 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23 any injury or other traumatic event, in Medical Estating memory.

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**Physician** 

/Medical

**Examiner** 

Physician/Medical Examiner

by

Completed

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Certification:

edical

(Check only one)

29b. Signature and late of corpum

Baltimore, Maryland 21215-0020

the Maryland

with

State Registrar

Au 31. Dete filed (Month, Day, Yeer) 1 1999 JUN

30. Name and address or person who completed cause of death (Item 23a) (Type, Print)

PAUL SchwARTZM.D. 115 E. SCHWARTZ M.D. 32. Registrar's Signature

AHERDING

Meleoge Are 21212

29c, License number

29d. Date signed (Month, Day, Year)

The way from I pleased

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Amended#20b,20c perFH G772 6/1/99 EW Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician MA F551 1999 ARIAH 10RRIS 1A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner SALTIMORE HUSPITAL If Under 1 Year If Under 24 Hrs. 5. Social Sacurity Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 M 2XX 57 Yrs Director 169-34-1797 GA Usual Residence of Decedent the Merylend 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or frame 23a or 28a-f ahow traumatic event, the Medical Examinar must be mortified at 1☐Yes 2☐No Baltimore Director MD NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 1 Apt.1-B 702 Nottingham Road 21229 USA Funeral death 14. Race - American Indian. 12. Was Dacedant Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) Black, White, etc. 2 should be filed within 72 hours efter and Mental Hygiene. Is marked other than "natural", or has 1 Yes 2 No If Yes, Give Yaar or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: p 3 Widowed 4 XDivorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Customer Service Rep. High Sch, Grad NA Loomis Fargo Co. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumema) Be Willie Sim Mamie Wilcox 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19146 19e. informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Heelth and Important: If item 27 is m any injury or other traum Simms 1529 S. Patton Street Philadelphia , PA. Annette 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Nat 1 Me 1 Memoria Mem.PK. Cem 05-28-99 Laurel, MD 21. Signature of Funeral Service Licenses 22. Nama and Address of Facility Baltimore, Maryland 21202 ere WM.C. March FH 1101 E. North Avenue Approximate Interval Between Onset and Death art1. Enter the disease or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, book, or harm failure. List only one cause on each line. Physician /Medical TERINE SARGOMA Immediate Ceuse (Fine) disaase or condition resulting in death) Examiner Due to (or as a consequence of) Examiner attending physician end for use as the burial-transit Sequentially list conditions, if any, leading to Immediate cause. Enter Undarlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, certificate be Physician/Medical Due to (or as a consequance of): signed by the a 23b. Did tobacco use contribute to the cause of death? Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably Unknown 1 Yee 2 No à 24b. Were eutopsy findings available prior to completion of cause of death? should 24e. Was an autopsy Completed page 2 hes 1 ☐ Yes 2 ☐ No 1 Yes 2 No certificete 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Othar: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yas 20-No To 1 Inpatiant 2 □ ER/Outpatient 3 □ DOA After this funarel 28a. Date of injury (Month, Dey Year) 28d. Describe how Injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury at Work? Certification: Neturei 2 Accident Attending 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after deel 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 5 Hospital 24 hours 29a. Certifier tig Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner es eteted. edical To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Dev. Year) 29b. Signature and title of cartifier 10 30. Neme and address of person who completed cause of death (Item 23e) (Type, Print)

PAUL

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32. Registra

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BACTIMIRE, MO

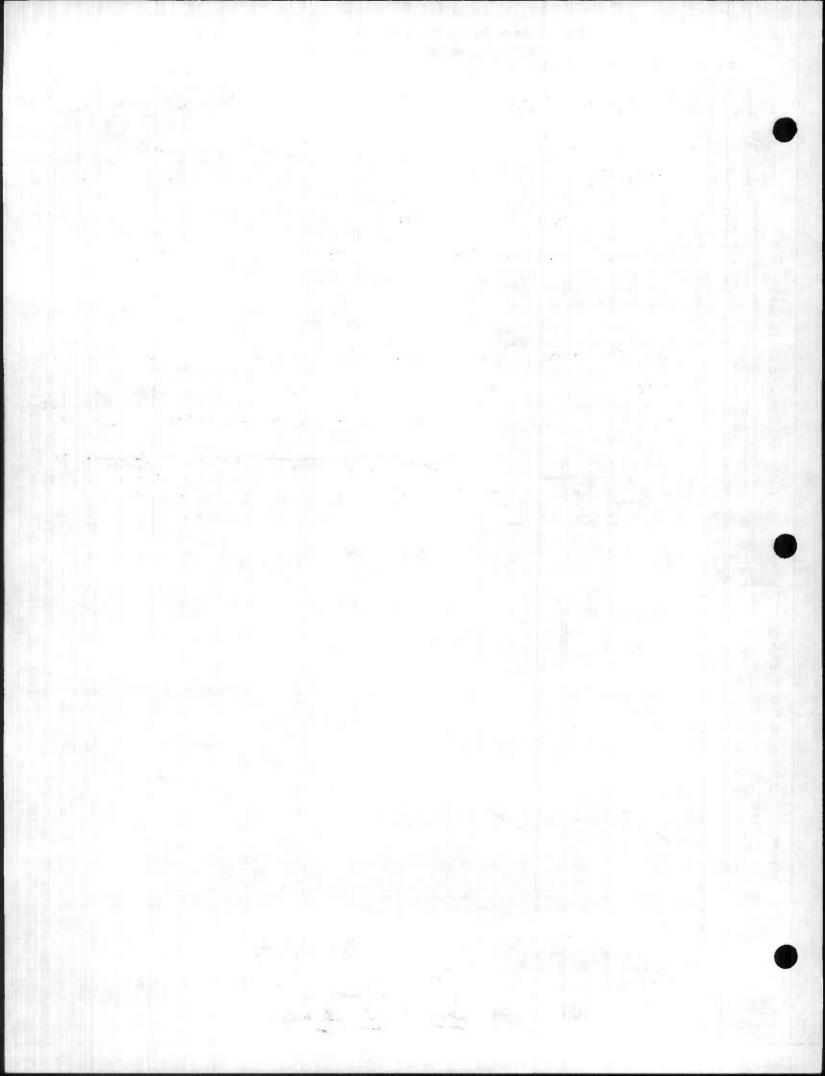
State

Registrar

JOSEPH JOSEPH

31. Dete filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene

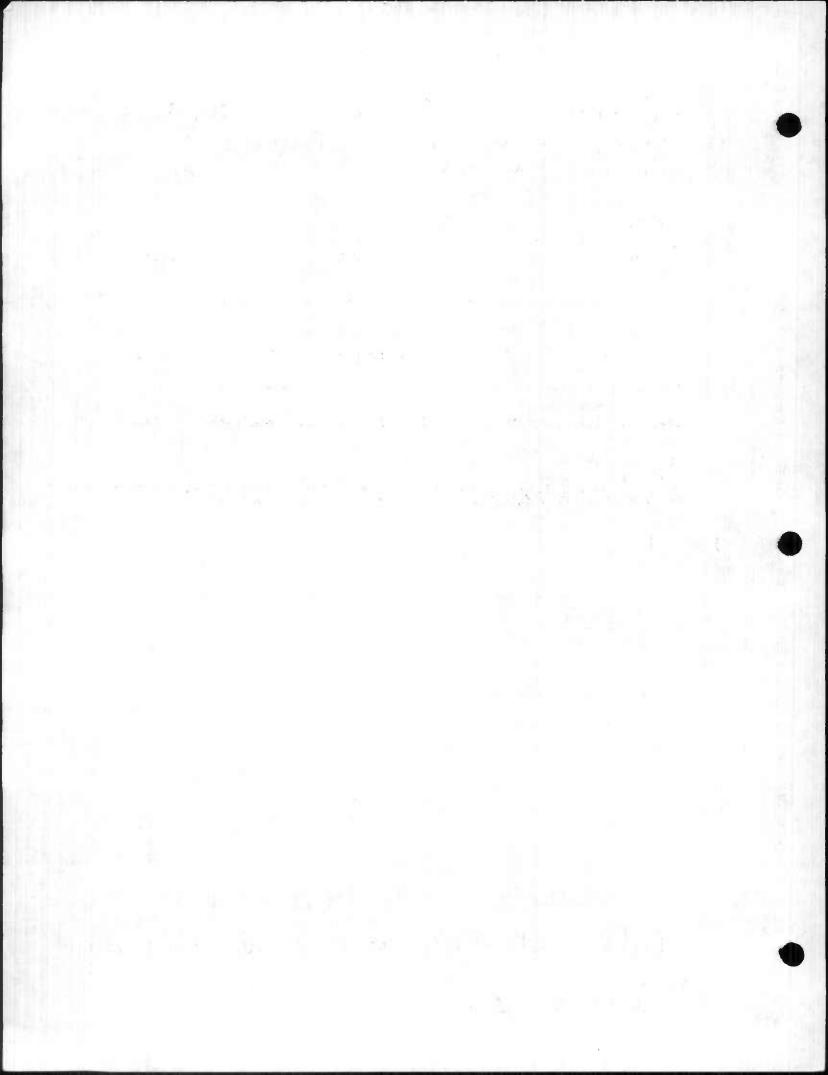
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al, or items 23a or 28a-fs Examiner must be notified by Funeral Director		11. Marital Status  1 Never Married 2 Married  3 12 Widowad 4 Divorced	12. Was Decedant Evar in Armed Forces?  1 ☐ Yas 2 ☒ No If Yes, Give Yaar or Dates:	U,S.	13. Was Dec	edent of H	ispanic Origin? ( an, Mexican, Pua Specify:	Specify Yes or No Into Rican, etc.)	)- 14. Rad	ca - Amarican i ck, Whita, etc.	marican indian, hita, etc. white		
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7 is me trauma	19a. Informant's Name/Relationship (Type, Print)  Lewis H. Miller/nephew  19b. Mailing Address (Street end Number or Rural Route Number, City or 1808 Windsor Dr., Bloomington, Inc.)												
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he Funeral I pletaly filled edical Ce	l.	(Check only one)	sician: To the best of my ki nsr: On the basis of exemi and manner stated.	nation and/o	eath occurre r investigetio	d at the timen, in my of	ie, dete and plac pinlon, death occ	e, and due to the curred at the time,	cause(a) and me date and place,	and due to tha	l. cause(s)		
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	4	0. Name and address of person who co			pe, Print)	Park	Wan B	actimo	re 217	14	in the second		
State Registrar		11. Date filed (Myth Pa, Organ) 199			1	1			- =(2				



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death MOGENSEN 2 Day 1515 ANKER MAY 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death RANDALISTONS BALTIMORE NORTH WEST HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Months Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) HOKM 20 F Months Days Hours 219-14-1445 January 10, 1916 Denmark Disual Residence of Decedent 10a Stata 10b County 10c. City. Town or Location 10d. Inside City Limits 1□ Yas 2☑ No Maryland Baltimore Villa Nova 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4115 Essex Road 21207 United States 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ZYes 2 No If Yas, Give Year or Dates: WW II 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Anker Masonry Elementary/Secondary (0-12) 12th College (1-4or 5+) Self-Employed Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jens Christian Mogensen Aline Marie Nielsen 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD 21207 Virginia Mogensen (Wife) 4115 Essex Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) MD Veterans Cemetery 6/1/99 Garrison, Maryland 22. Nama and Address of Facility 21. Signature of Funeral Service Licenses Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133-4784 WWW M10333 23a. Parf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, about, or heart feiture. List only one cause on each line. Approximata Intervat Between Onset and Death Immediata Cause (Final disease or condition resulting in death) SEPSIS WITH MULTI ORGAN FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? STRANGULATED HIATAL HERNIA 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of causa of death? 24e. Wes an autopsy performed? 1 Yes 2 No 1 Yas 2 No 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 □ Chpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 28a. Data of trijury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 6 ☐ Could not be determined 3 Suicide 28e. Plece of tnjury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

**Physician** /Medical Examiner

Physician

/Medical

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**Funeral** 

Director

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permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mertal Hygiena. Important: If them 27 is married other than "natural", or then any injury or other traumatic event, the Medical Examination.

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Physician/Medical Examine To Be -Certification: Alber

Records, P.O. of Vital Division or Attending a after de al Director: AP 24 hours at Funeral D stely filled

Registrar

29b. Signature and title of certifier an 29c. License number 037333 29d. Data signed (Month, Day, Year) MAY 27, 1988

30. Name and address of person who completed causa of death (ttem 23a) (Type, Print)

MO, NHC, BALTO MD 21133 C. PAVI 31. Date filed (Month, Day, Year)
JUN 0 1 1999

32. Registrar's Signature

DHMH 16 Rev 6/95

adical

(Check only one)

Joseph Wille Harry

#### Please Type or Print In Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 1999 MOHRE 5:35 p.m. May HELEN 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street end number) Baltimore Pickersgill Retirement Community Towson Hours Min. July 24, 1915 9. Birthpiece (State or Foreign Country) Mary Land 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 6. Sex Deys Months 1□ M 2X F 83 220-46-0312 Usuei Residence of Decedent 10d. Inside City Limits 10a, State 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Maryland Baltimore Towson 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21204 U.S.A. 615 Chestnut Ave. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Detes: Rece - American Indian, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 Never Married 2 Married 1□ Yes 2⊠ No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Eiementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Zimmerman Burgemeister Anna Frederick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13909 Fox Land Road Phoenix, Maryland 21131 Son Robert F. Mohre 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20e. Method of Disposition Date cemetery, cremetory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. Gdns.6/2/99 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility. Mitchell-Wiedefeld Home Inc. 21. Signature of Funeral Service Licenses ober 6500 York Rd. 21212 23a. Part1. Enter the disease, or complications that ceused be death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final pneummin disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury lhat initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es e consequence of): Part if, Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of ceuse of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 26b. Time of 28c. Injury al Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes investigation 6 Could not be determined 3 Sulcide 28e. Piace of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the Ilme, date and place, and due to the cause(s) and manner stated. 29e. Certifier

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, ed by the e s certificata has b or Attending Physician: death. - 24 hours aftar death. - Funerel Director: A pletaly filled in by the fu Hospital To the Within 2

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29b. Signature and title of certifier

31. Date filed (Month, Day, Yea

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1999

**Funeral** 

Director

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Peges 1 and 2 should be filed within 72 hours efter death with the Maryler nent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or items 23a or 23a-f ahow try or other traumatic avent, its Medical Entiries in mail to roof and arry or other traumatic avent, its Medical Entiries in mail to roof and any or other traumatic avent, its Medical Entiries in mail to roof and any or other traumatic avent, its Medical Entiries in mail to roof and any other traumatic avent, its Medical Entire of the contract of the con

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State Registrar

DHMH 16 Rev 6/95

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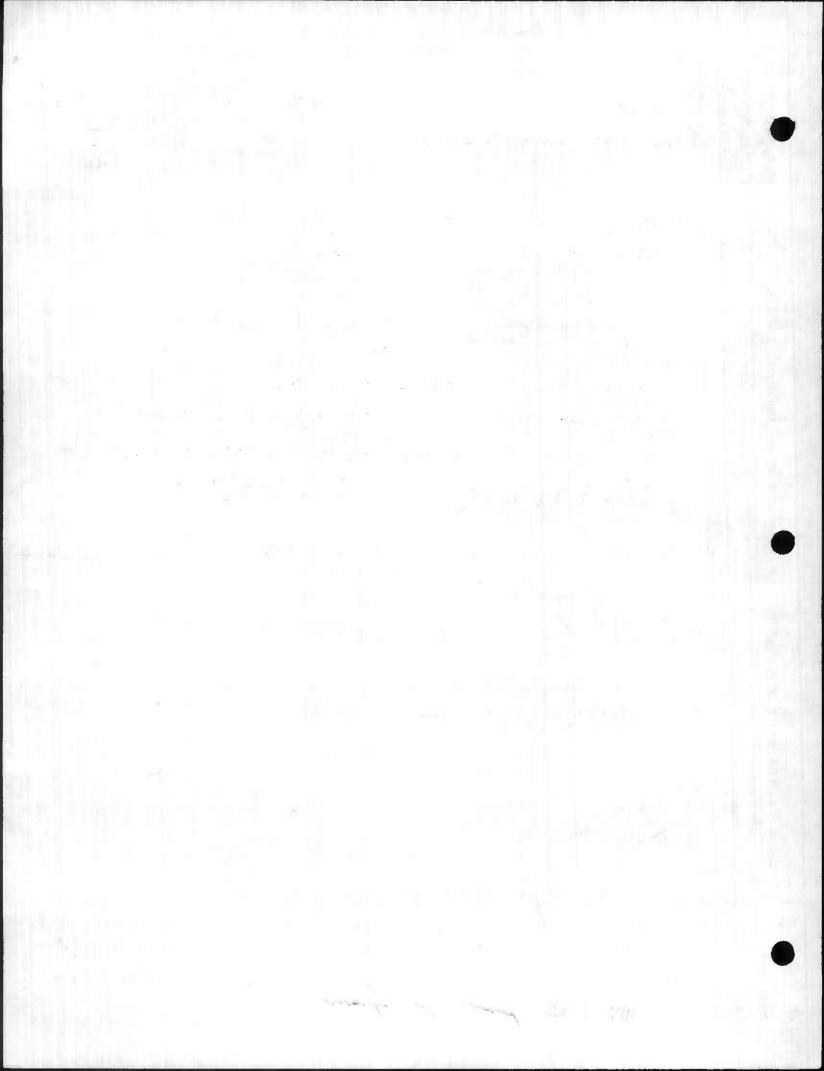
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N. Charles St.

lise of death (Item 24a) (Type, Print)

6-BMC

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED ITEM #23b PER MD G773 7/19/99 AH 1. Decedent's Name (First, Middla, Last) 3. Time of Death 2. Date of Death **Physician** 1999 May 22, ELBERT RAY NUTTLE JR. 4:42AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street and number) Examiner Gilchrist Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Data of Birth
Months Days Hours Min. (Month, Dev. Year)
February 26, 1929 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** XXM 2DF Yrs. 70 220-22-5570 Maryland **Director** Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notited at 1 Yas 2 No Directo Maryland Baltimore Towson 10f. Zip Code 10g. Citizan of Whet Country? 10e. Street and Number with 299 Alabama Road 21204 USA Funeral 72 hours after death 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 (M) to If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian. 11. Marital Status Bleck, White, etc. 1 Never Merried Merried . 00 1 ☐ Yas 2XXNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 I Hygiene. College (1-4or 5+) Elementery/Secondary (0-12) permit. Peges 1 and 2 should be filed with Department of Health and Mental Hygien Important: if item 27 is marked other that any lojury or other traumatic event, the page. Engineer Manufacturing 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fathar's Nama (First, Middla, Last) Elbert Ray Nuttle Sr. Margretta Virginia Pyles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Wife 299 Alabama Road Towson, Maryland 21204 Jayne R Nuttle 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition ₩XBurlal 2 Cremation 3 Removal from State 5/29/99 Bee Tree Cemetery Parkton, Maryland □ Donation 5 □ Other (Specify) 22. Name and Address of Facility dignature of Funeral Servine Lip Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 23a, Parti. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximate Intarval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Physician/Medical Examiner disense OVONA ician and burial-transit that the deeth certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest attending physician for use as the buria Box 68760, Due to (or as a consequence of) 80 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 1X Yes 2 No 3 Probably 4 Unknown Ž 24b. Were autopsy findings available prior to completion of cause Completed 24a. Wes an autopsy PB8 page 2 1 Yes 2 No 1 Yas 2 No certificate Division of Vital 25. Was cese referred to medicel examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Hospic 1 Yes 2 No To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Data of Injury (Month, Day Year) 28d. Describe how Injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury et Work? Certification: 5 Pending Investigation Attending 1 Neturel 2 Accident 1 Yes 2 No or Attend after death Director: 3 Suicide 6 Could not be 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, straet, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) 29b. Signature end itie of 29c. Licansa number 29d. Data signed (Month, Day, Year) 25205

State Registrar

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Game 6281 N-Charles St. Belto. Md. 21204 6781 32. Registrer's Signeture

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month MAY **Physician** 1000 28, 8:05 PM Raymond D. Pearce /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death **Examiner** Baltimore Towson Gilchrist Center 8. Date of Birth Month Day, Year) 15 9. Birthplace (State or Foreign Country) Virginia 5 Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1₽M 2□ F Months Deys Hours 83 Yrs. 225-07-6102 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 le marked other than "naturel", or itema 23a or 28a-f ehow treumatic avent, tre Maoiral Examiner must be notified as MD Baltimore Catonsville 1 ☐ Yes 2 No Director 10e Street and Numbe 10f. Zip Code 10g. Citizan of What Country? 21228 IISA 1423 Pleasant Valley Drive Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No WW II I Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, atc. 1 Never Married 2 Married White 1 Yes 2 No Specify: Š 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) Industrial Sales Rubber Products 18. Mother's Name (First, Middle, Malden Sumame) 17. Father's Name (First, Middle, Last) Raymond D. Pearce, Sr. Annie Pritchard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 1423 Pleasant Valley Dr. Catonsville, MD 21228 Jacklyn Pearce/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 MCremation 3 ☐ Removal from State Injury or Metro Crematory, Inc. 5/29/99 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Cremation Society of Maryland, Inc. any ir 299 Frederick Rd. Baltimore, MD 21228 23a. Part. Enter the disease, or complications that ceusad the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onsat and Death **Physician** /Medical Immediate Cause (Final disease or condition rasulting in death) Years Examiner Physician/Medical Examiner ettending physician and for use es the bunal-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disaase or Injury that initiated events Due to (or as a consequence of) Due to (or as a consequence of) resulting In death) Last 23b. Did tobacco use contribute to the cause of death? ed by the datached Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part f. 1 Yes 2 000 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of ceuse of death? 1 ☐ Yas 2 ☐ No director. Be 25. Was casa rafarrad to medicel examiner? 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hoppice 9 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 5 Pending 1 Watural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be datermined 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) filled in by 4 Homicida 29a. Certifier 1 Contifying Physician: To the best of my knowledga, death occurred at the time, data and place, and dua to tha causa(s) and manner as stated. edical 2 Medical Examinar: On the basis of examination and/or investigation, In my opinion, death occurred at the time, data and place, and dua to the cause(s) end menner stated. (Check only one)

State Registrar

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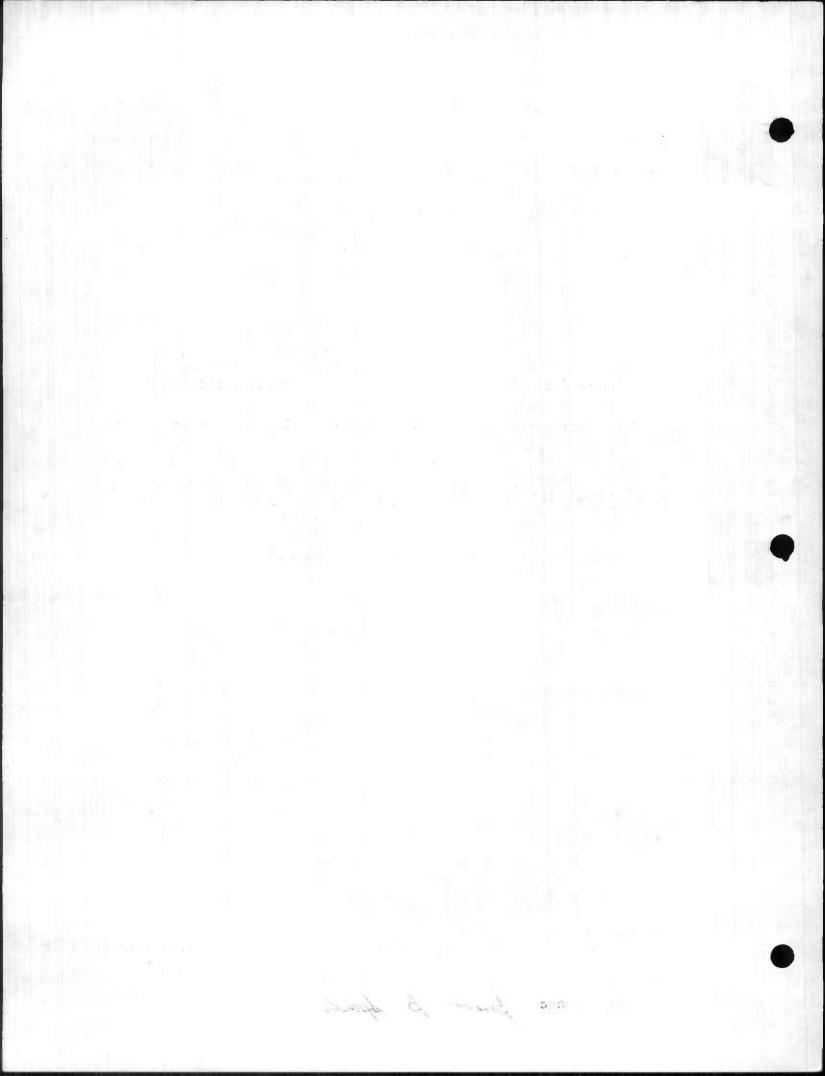
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29c. License number

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State of Maryland / Department of Health and Mental Hygiene									
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State Registrar

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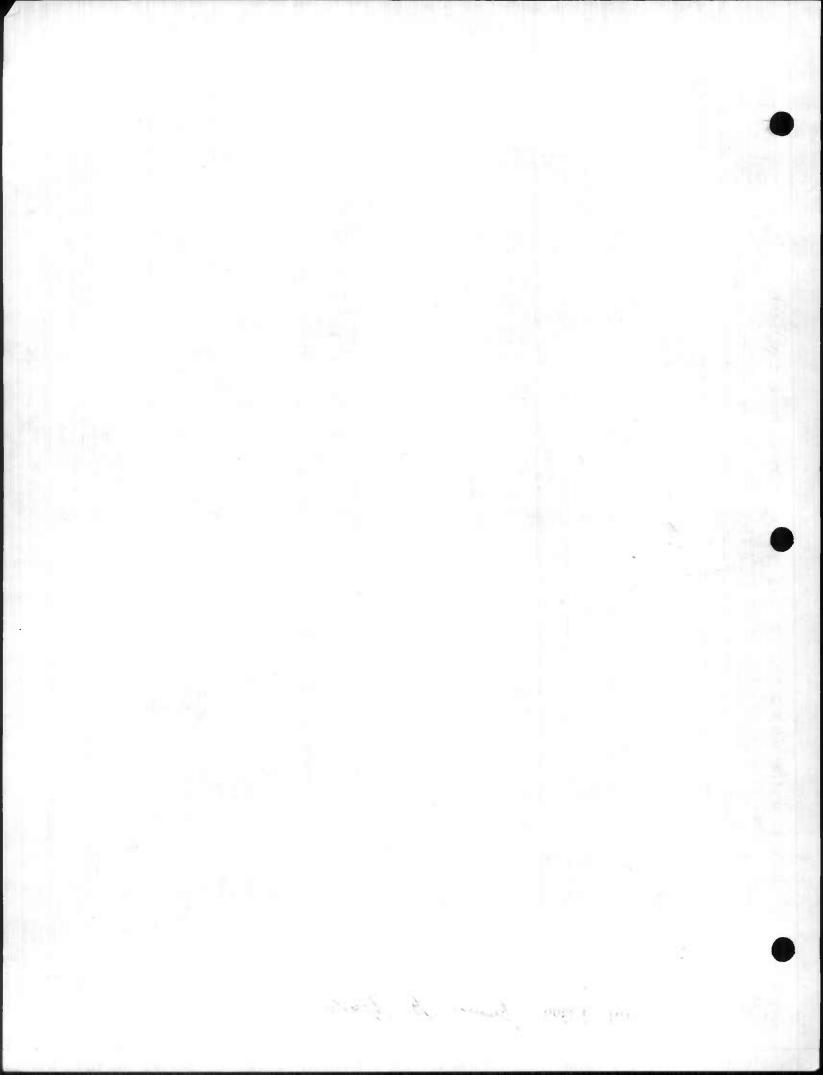
29c. License number

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DHMH 16 Rsv 6/95

ed ceuse of death (Item 23e) (Type, Print)

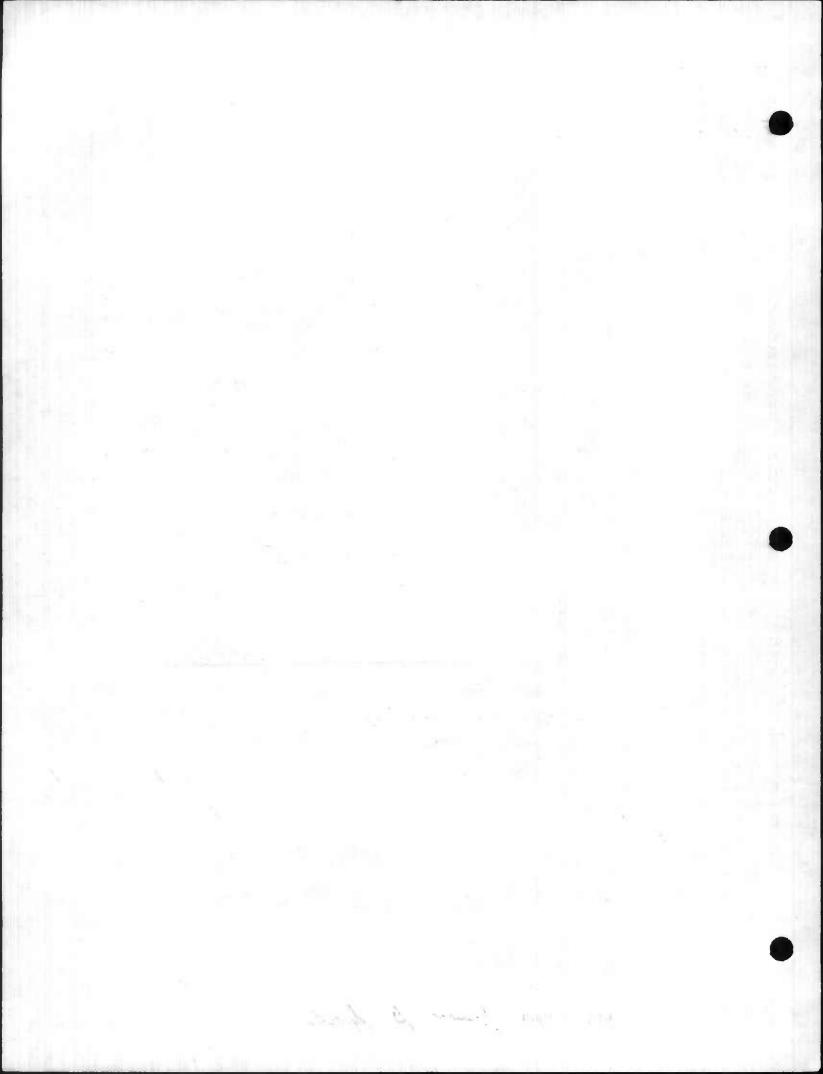


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I	TEM: #23 F	PAR	T I PER MEO G	772 6-1-9		marylan		tificate of	Death	nental Hy	Reg. No.	9	17405		
	Physiciar /Medica	n	1. Decedent's Name (First, Middle, Last)  Isabell M. Parks							2. Date of De Month May	Day	Year 1999	3. Time of Death 12:47 P.M.		
r	Examine	•	4a Facility Name (If not institution, give street and number)  4b. City, Town, or Lo								h 4c. County	of Death			
			4824 Mountain Road Pasadena								Anne				
	Funeral Director		5. Sociel Security Numb	716 1	6. Sex 1 □ M 2 🖫 F  7. Age (In yrs. last birthda 71 Yrs.			Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, De May 3,	Day, Year) C		lace (Stete or Foreign try) ryland		
	death with the Manyland rms 23a or 28a-f show rms to be notified at		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location									1	Od. Inside City Limits		
	he M	Directo	Maryland Anne Arundel Pasadena  106. Street and Number 10f. Zip Code								10g. Citizen of What Country?				
	With No.	히						2112	22		U.S	nry r			
	ne 23a	era	11. Marital Status 12. Wes Decedent Ever in U,S.							ecify Yes or No					
020	or the	by Fur	1 ☐ Never Married 3 ☑ Widowed 4 ☐		Armed Ford 1 Yes 2 If Yes, Give Year or De	ces? 2[K] No		Yes, specify Cube  ☐ Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Specify	k, White,			
5-0	n 72 hours natural, polical Ex	De le	15. Decedent's Education (Specify only highest grade completed)				16a. Deced	ent's Usual Occup	petion	ina	16b. Kind of Bu	siness/Inc	dustry		
21215-0020	s 1 and 2 should be filed within 72 hours Hasth and Mental Hygiene. Item 27 is marked other than "natural", other traumatic avent, the Medical Exi	Completed	Elementary/Secondery (0-12) College (1-40r 5+)					emaker	during most of work d)	Own	n Hom	e			
pu	al Hy I othy	Be	17. Father's Name (First	t, Middle, Last)			18. Mother's Name (I					Θ)			
yla	Ment Ment arked	0	Norman Proctor Ma							ry Hall	l .				
Maryland	is mark		19a. Informant's Name/			_			and Number or Rur		110				
	Hasith lem 27 other tr	-	Charles A		Jr. /			Mountain	Road		na, Mary				
Baltimore,	permit. Pages 1 and 2 since Department of Haelth ar Important: If Item 27 is any injury or other traughts.	-	20a. Method of Disposition  1  Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Placa of Disposition (Name of cemetery, crematory or other place)  Clen Haven Memorial Park 5/14/99 Clen Burnie, Maryland  21. Symmune of Funnyal September 1 September 2 Septem												
Bal	Departiment Important Impo		21. Signature of Furness	Hace	28.7	O or	*	Name and Addre	ie Highwa		Funeral l				
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		-					or as a consequ								
	uted d ansit	Examiner			b		RY ARTER	Y DISEASE				1			
ó	physician and s the burial-transit	LX.	Sequentially list condition if any, leeding to immediate. Enter Underlying Cause (Disease or Injury)	diate		Due 10 (c	as a consequ	delice oij.							
68760,	lysicia he bu	CO I	Cause Disease or injury that initiated events resulting in death) Last  C. Due to (or as e consequence of):  C. Due to (or as e consequence of):												
Вох 68	5 00	Physician/Medi								Dise					
	death ed for u	SICIE	Part II. Other significant	t conditions of	ontributing to dea	th but not res	ulting in the un	derlying cause giv	ven in Pert I.	23b. Did	tobacco use co	ntribute to	the cause of death?		
s, P.O	5 00	Dy Phy	Cerebrovascular accident.							1 Yes 2 No 3 Probably 4 Unknown					
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O	funer funer	LION	1 Natural 5	Pending investigation		Day Year)	28b. Time of Injury	28c. Injur Wor M 1 □	yat nk? Yes 2 □ No	280. Describe	how injury occur	ea			
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	outhin To the comple		29b. Signature and title	of certifier				29c. Licens	e number		29d. Date signe	d (Month,	Day, Year)		
	- > - 0		<b>)</b> C	Landac	e Chard	le v	· Q	D	2920	9	5-18	2-9	9.		
			30. Neme and address of	of person who	completed cause	of death (Iten	23e) (Type, F		Pasad		mo an	22	14 14 15		
	State		31. Date filed (Month, Da	ay, Year)	32. Re	gistrar's Signa	iture			-110	,				
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DHMH 16 Rev 6/95

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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 7-30 pm 1999 Dons revolue ai 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anindel Anne If Under 24 Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months 1 M 2 F Hours 551-34-0104 March 16, 1926 Kentucky Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. inside City Limits 1 ☐ Yes 2 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8211 Box Drive 21122 S. A. 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ZCXNo If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: 3☐Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cisco Gurney Adams Kelley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbie Murphy (Daughter) 8211 Box Drive Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5/31 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Docks Creek Cemetery 1999 Kenova, Kentucky ure of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral Home PA 1 Second Avenue S. W. Glen Burnie, MD dga 21061 Ow 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STIAGE CHRONIC OBSTRUCTIVE AIRWAYS DISEASE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 □ Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Piece of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

MAY

29d. Date signed (Month, Day, Year)

1999

**Physician** /Medical Examiner

Physician

/Medical

Examiner

**Funeral** 

Director

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permit. Peges 1 and 2 should be filed within 72 hours effect. Department of Health and Mental Hygiens. Important: if frem 27 is marked other than "natural", or frem only injury or other treumatic event, the Healton Exercised once.

Baltimore, Maryland 21215-0020

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Examin 8 2 Certification: To the Hospital or Attending within 24 hours efter death.

To the Funeral Director: Afte completely filled in by the fun.

Physician/Medical P Completed

2 188 certificate this

State Registrar

**DHMH 16 Rev 6/95** 

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31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

1 Yes 2 No

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

30. Name and address of person who completed cause of death NORTH TRUNDEL HOSPITAL,

28a. Date of Injury (Month, Day Year)

5 Pending investigation

6 Could not be

Physique 1 of the print SUDHIR KUMM AGGARMAL 21061
PL, 301 HOSPITAL DRIVE, GLEN BURNIE, MD 21061 32. Registrar's Signature

1 Anpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify)

28b. Time of

mD

Lucisi

28c. Injury at Work?

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

ner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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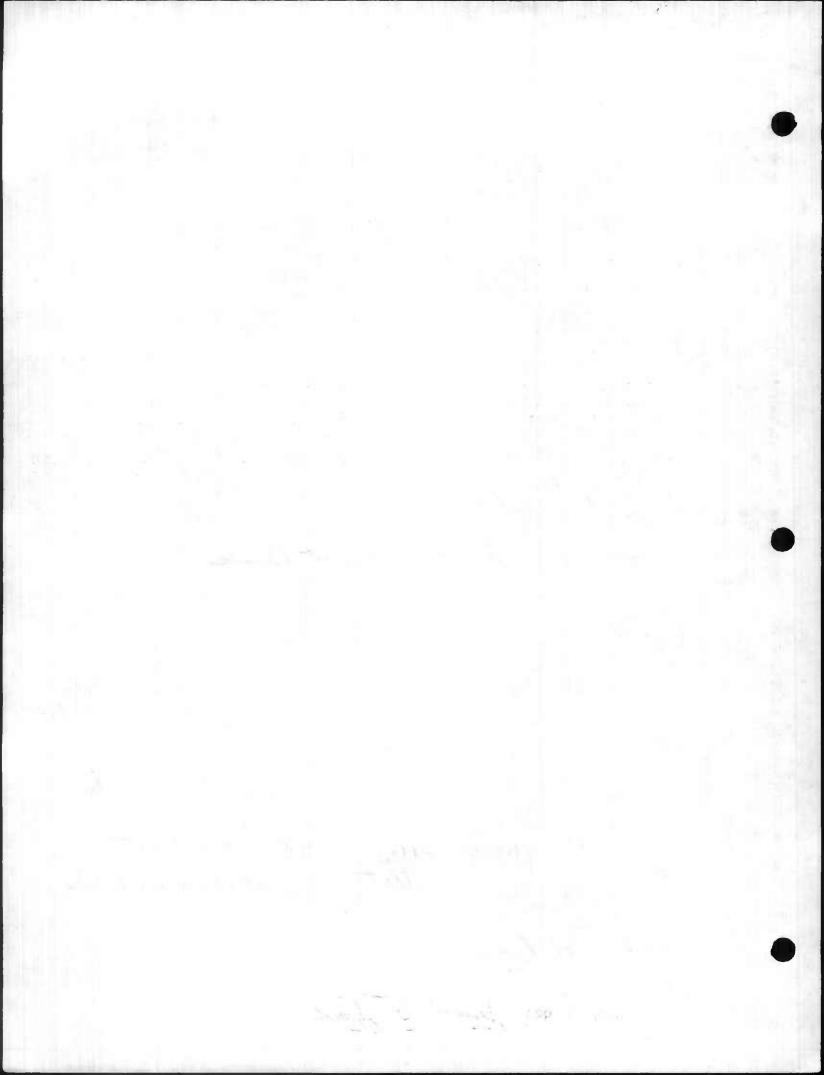
State of Maryland / Department of Health and Mental Hygiene 

O UNKNOWN 99-114 Certificate of Death HOWARD B. RICE 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Day Yaar **Physician** Howard 2156 PM MAY 25, 1999 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** UNIVERSITY HOSPITAL S.T.U BALTIMORE 5. Social Security Number 7. Aga (In yrs. last birthday) If Under 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** 1 M 2 □ F Months Days Hours 31 213-80-6522 Director 01-15-68 MD Usual Rasidance of Decedent 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Exemples must be notified at No Yas 2 No MD Director NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Apt.A-1 21218 USA death 312 East 20th Street 12. Was Deced edant Evar in U.S. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status Armed Forcas Black, Whita, atc. 72 hours after 1 Yas 2 No 1 Navar Married 2 Married Baltimore. Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify: Black P 3 Widowed 4 Divorced Yaar or Datas Completed 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry filed within 7 Hygiena. Elemantary/Secondery (0-12) Coltega (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiena Important: if them 27 is marked other tha any Injury or other traumatic event, the 1, 12th Grade NA Full-time Pets Smart 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Surnama) Benjamin Thompson Denise 19b. Mailting Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 21218 19a. Informant's Name/Raiationship (Type, Print) Vera Turnage 312 E. 20th Street Apt.A-1 Baltimore, MD. 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata X Burial 2 Cramation 3 Removal from Stata Kings Mem. PK. Cem. 06-02-99 Randallstown, MD Penation 5 ☐ Othar (Specify) 21. Signature of Funeral Service Lio 22. Nama and Addrass of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23a. Part V Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tntarvat Batween Onset and Death **Physician** /Medical Immediata Causa (Finat disaasa or condition rasulting in daath) Examiner Examiner physician and the burial-transit that the death certificate be asscuted Sequanfially list conditions, if any, laeding to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated evants rasulting in death) Last Dua to (or as e consequence of) Box 68760 Physician/Medical Dua to (or as a consequanca of) P.O. | Part tt. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 3 signed b Records, þ law requires 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to Completed complation of causa of death? certificate Division of Vital despital or Attending Physician: TI 4 hours after death. \*uneral Director: After this certificately filled in by the funeral director, pa 8 25. Was casa rafarred to medical 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) XXYas 2□ No edical Certification: To 1 ☐ Inpatiant XX ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28a. Data of fnjury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. injury at Work? Injury 1 Natural 5 Pending 1 Yas Invastigation 2 Accident 116 6 Could not be datarmined 3 Suicide n (Street and Nu Town, Stata) Plece of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 4 Homicide Street To the Hospital or within 24 hours aft To the Funeral Di completely filled in Mystle avenue 1 Certifying Physician: To the best of my knowledga, daath occurred at tha time, dete end place, and dua to tha causa(s) and mannar as stated.

XX Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date end place, and dua to the cause(s) and mannar stated. 29a. Cartifier (Check only one) 29b. Signature and title of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) O.C.M.E MAY 26, 1999 neode 30. Name and address of person who co pleted causa of death (item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 HEDDORE MKIN Day, Year) 32. Registrer's Signati State + JUN

Registrar

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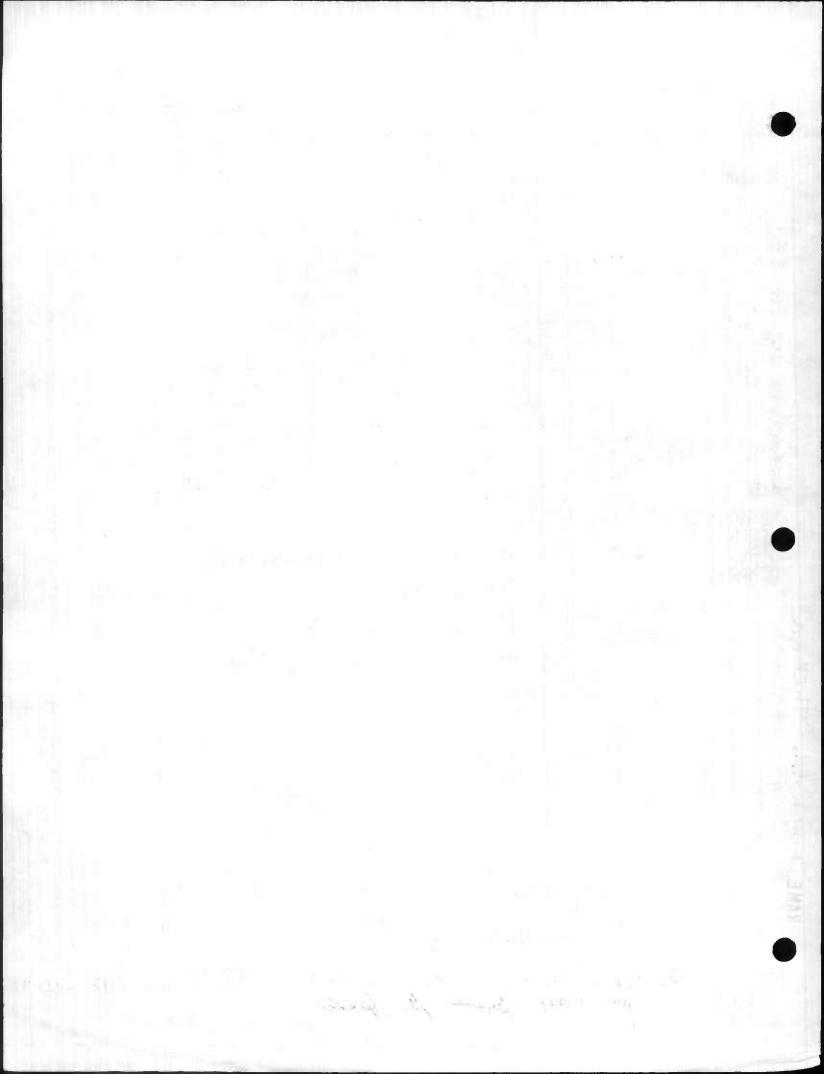


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State of Maryland / Department of Health and Mental Hygiene

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Exa	miner	St Agnes W		care		0 11	nore	n/a	y or Doalit			
Fune Direc		5. Social Sacurity Number 6. Sax 1 M 25	7. Aga (In yrs. 7	last birthday) 8	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Dela of Bir (Month, Da July 7	th ly, Year)	9. Birthple Counti Mary 1	ace (Stata or Foreign ry) and		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** RICE MARIAN 30 1999 6.429m /Medical 4e Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORECTY HOSPITAL BALTIMOKE OF N/A SINAI If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. 3/18/30 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Funeral 1□ M 201 F 69 MARYLAND Director 218-26-3775 Usual Rasidence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at MD BALTIMORE 1 ☐ Yas 2 No TOWSON Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or flams 23a or 1553 COTTAGE LANE 21286 Funeral USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. after 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2√ No Specify: À 72 hours 3X Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12th GRADE HOMEMAKER OWN HOME 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First Middle Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If New 27 is marked of FRANK MORRIS CATHERINE MURPHY 19e. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GARY RICE 551 BROOK ROAD TOWSON, MD 21286 20b. Place of Disposition (Name of 20e. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State ò 4 ☐ Donetion 5 ☐ Other (Specify) MORELAND MEMORIAL PARK | 6/2/99 HILLENDALE, MD 22. Name end Address of Fecility
THE JOHNSON FUNERAL HOME, P.A. 21. Signeture of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 Part. Ellier the disaese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiretory errest, shock, or heer feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final SEPSIS 6 week diseese or condition resulting in death) Examiner Due to (or as e consequence of): RENAL FAILURE The law requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): and Years IABETES Box 68760 attending physician Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. the à 1 Yes 2 No 3 Probably 4 Unknown signed b Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peeu page 2 2 NO. 1 ☐ Yes 2 ☐ No certificate Division of Vitai To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 M Yan Hospitet: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menyler of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Naturel 5 Pending 1 Yes 2 No investigetion 2 Accident 6 Could not be 3 ☐ Suicida 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 29a Certifier 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 21730 ari 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL OF BALTIMORE IARIQ KHAN SINAI 31. Deta filed (Month, Dey, Year) 32 Registrar's Signature State 1 1999 JUN Registrar

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**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

Director

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with the Maryland

death

Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite

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permit. Page Department of Important: If any Injury or

**Physician** /Medical

Examiner

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To the To the **DHMH 16 Rev 6/95** 

State Registrar

31. Dete filed (Month, Dey, Year) 1999 JUN

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30. Nama and eddress of person who complated causa of daeth (Item 23e) (Type, Print)

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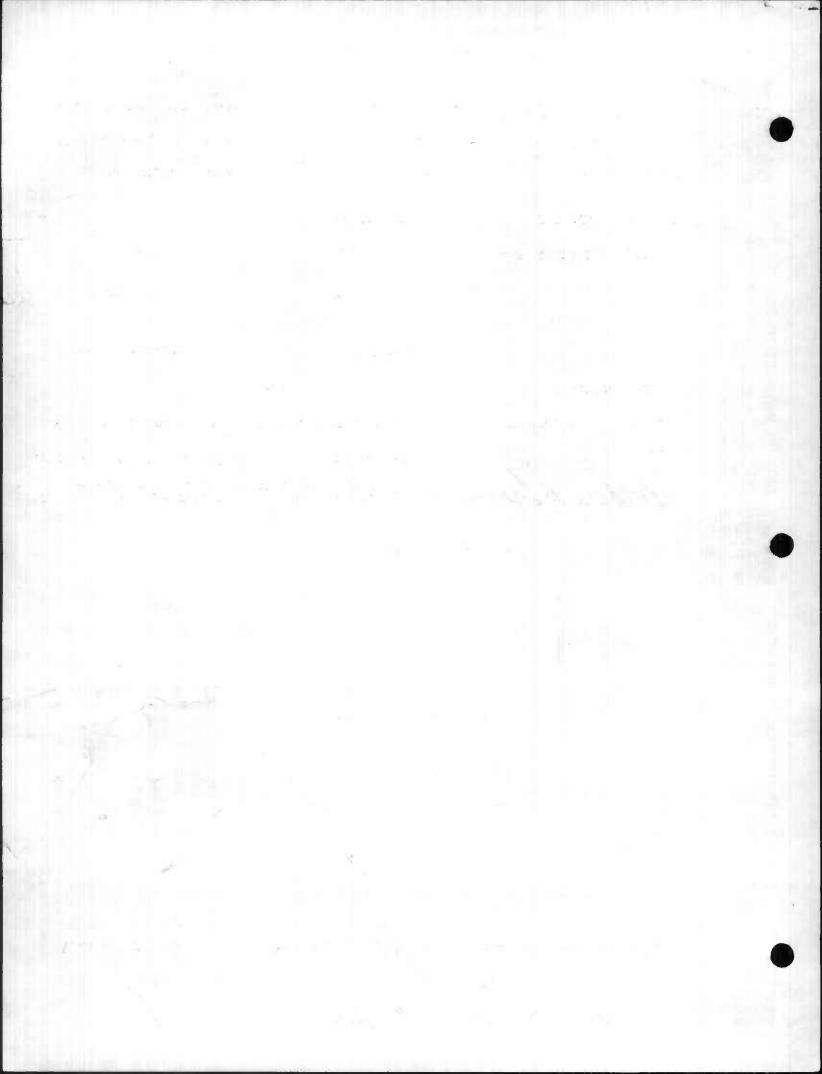
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ITEM: #12 PER F.H. G772 6-1-99 WR. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Day **Physician** may RIBACK **EMANUEL** 1999 25 /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AGNRS Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Months 219-01-2924 86 **Director** SEPT 16, 1912 POLAND Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or frame 23a or 28a-f show X□ Yes 2□ No Director MD N/A BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 22 SOUTH ATHOL AVE 21229 USA Funeral Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hyglene.
The marked other than "natural", or flore 23 my or other traumatic avent, are Medical Exercited my or other traumatic avent, are 12. Was Decedent Ever in U,S. Armed Forces? 1 [X] Yes - 2 (XNo-If Yes, Give Year or Detes: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: WHITE Aq 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ ATTORNEY AT LAW 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HARRY RIBACK EDITH ROSEFELD 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) CHARLES RIBACK (BRO.) 3315-A CLARKS LA BALTIMORE, MD 21215 20b. Place of Disposition (Neme of comptery, crematory or other plece)
RADOMER VEREIN 20e. Method of Disposition 20c. Location - City or Town, State 1X Buriel 2 Cremetion 3 Removal from State
4 Donation 5 Other (Specify) 5/28/99 ROSEDALE, MD 21. Signature of Fatheral Server License 22. Name and Address of Facility
SOL LEVINSON &BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD disease, or complications that ceused the death. Do not enter the mode of dylng, such as cerdiac or respiratory arrest, tailure. 23a. Part1. Enter Ib Approximete Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical . End disease Veors Stage renal Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Physician/Medical Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown myocardia intarction þ 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed Rectal Carcinoma 1 ☐ Yes 2 No 1 ☐ Yes 2 No NAME 17 1 bae 25. Wes cese referred to medical examiner? Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? Certification: 5 Pending investigation or Attending 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier edical (Check only To the Verthin 2 To the Comple 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Wong 10883

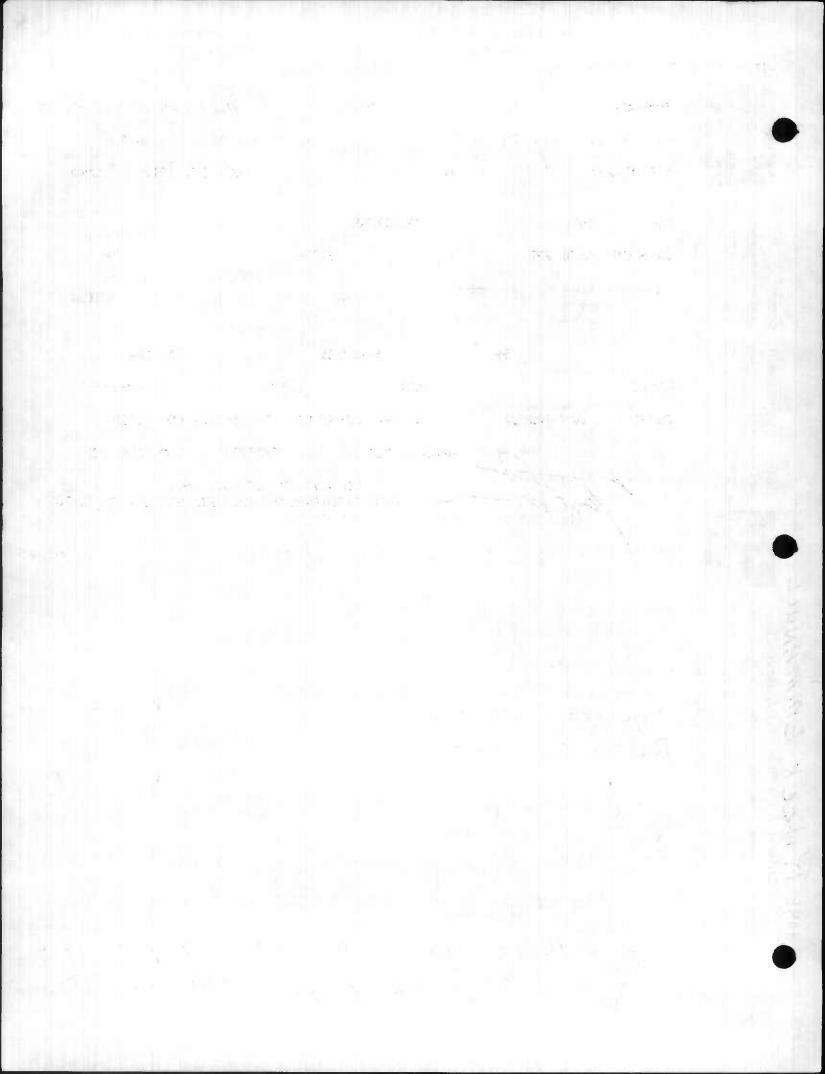
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State Registrar Henry

30. Neme end eddress of person who completed ceuse of death (Item 23a) (Type, Print)

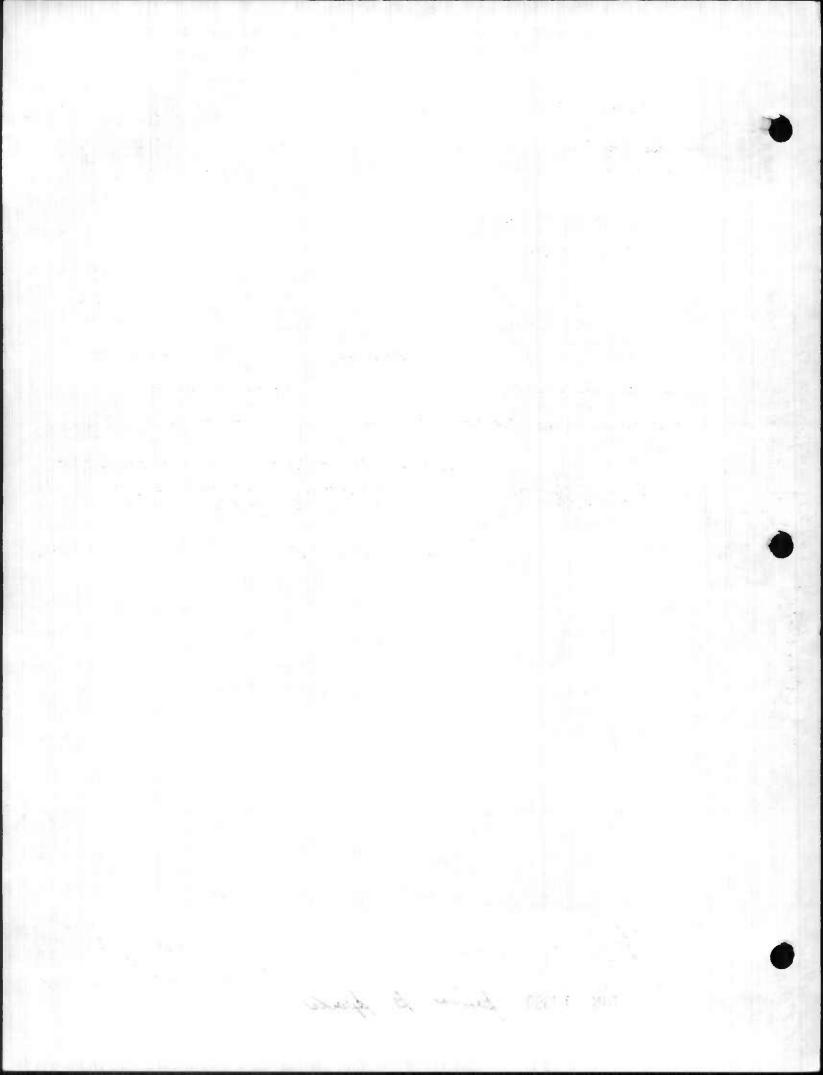
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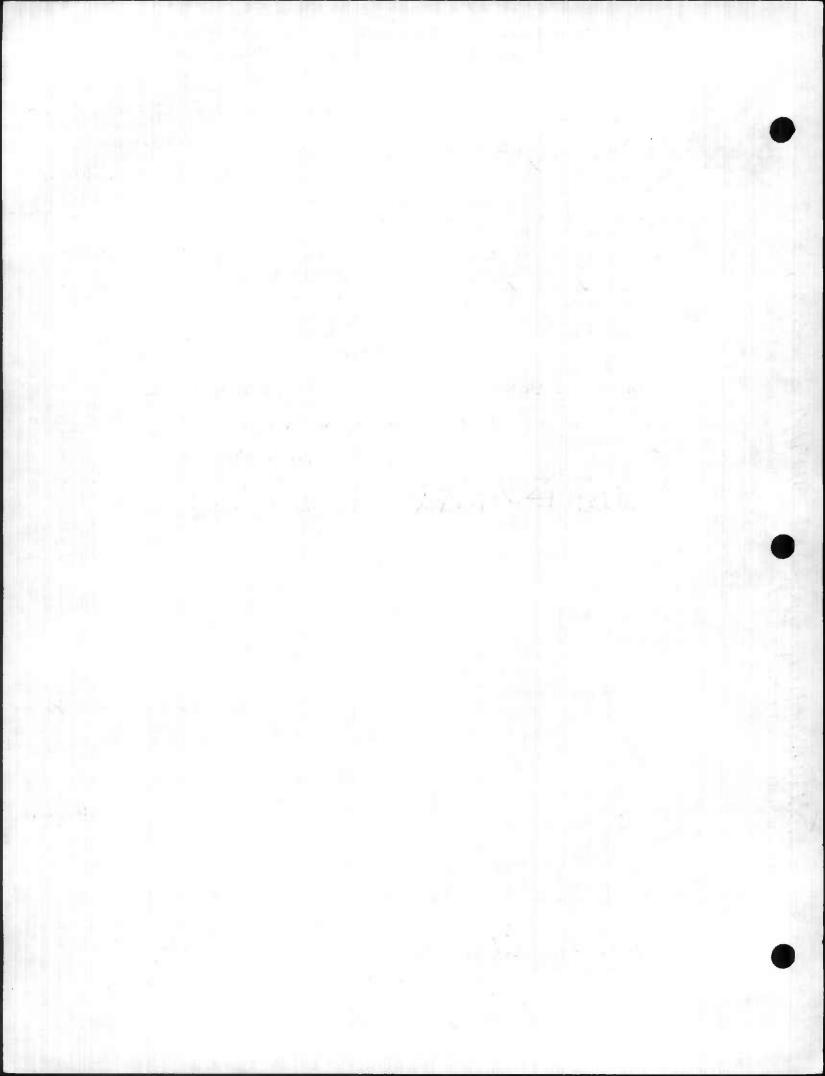


#### Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Name (First Middle Last) 2. Date of Death **Physician** DOROTHY EILEEN LIPPY RICKETTS May 27, 1999 7:30 AM /Medical 4c. County of Death 4a Fecility Name (If not institution, give street and number) Examiner Hospice of Baltimore: Gilchrist Center Baltimore County TOWSON If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min 1□ M 2Ū F Months Hours 77 213-16-0806 Director Feb 18, 1922 Maryland Usual Residence of Decedent the Marylend 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Maryland Baltimore County Timonium Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or itema 23a or 124 Tregarone Road 21093 USA Funeral filed within 72 hours efter death Hygiene. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced the Medical Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Accounting 12th Bookkeeper 18. Mother's Name (First, Middle, Maidan Surname) 17. Father's Name (First, Middle, Last) Be Peges 1 and 2 should be finent of Health end Mentel First: If Item 27 Is marked of George William Lippy Hattie Florence Hale 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant'a Name/Relationship (Type, Print) 124 Tregarone Road, Timonium, Maryland 21093 Kathleen A. Stewart (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Important: If It eny Injury or o ¶ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 Donation 5 Other (Specify) Dulaney Valley Mem Grdns 6/1/99 Timonium, Maryland 21. Signature of Funeral Saving Chenses 22. Name end Address of Facility Lusen Mitchell-Wiedefeld Funeral Home, Inc. PIRICITI D. MANSON 6500 York Road, Baltimore, Maryland 21212 23a. Part. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximately a such as cardi Approximeta Interval Between Onset end Death Physician Immediate Cause (Final disease or condition rasulting in death) /Medical 1ear Examiner Dua to (or as a consequence of) Examine physician and the buriel-transit Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disaase or injury that initieted events resulting in death) Lest Due to (or as a consaguanca of): Physician/Medical Due to (or as a consequence of): 98 980 23b. Did tobacco usa contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings evellable prior to 24a. Wes an eutopsy performed? Completed completion of ceuse of death? certificate hes t 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medicel axaminar? Be 26. Piace of Death (Check only one) To Other: 4 Nursing Home 5 Residance 6 Sother (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28c. Injury at Work? 28d. Dascribe how injury occurred 27. Manner of Death 28b. Time of Certification: 28a. Date of Injury (Month, Day Year) Attending 5 Pending Invastigation 1 Natural 1 Yes 2 No 2 Accident after deeth Director: 28e. Place of Injury - At home, ferm, street, factory, office building, atc. (Specify) 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 24 hours after Funeral Direction 4 Homicide ò 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and due to the cause(s) and manner as atlated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier Medical completely (Check only one) To the Vithin 2 29d. Date aigned (Month. Day, Year) 29b. Signature and title of certifie 29c. License number , mo posted cause of death (Item 23a) (Type, Print) V. Charles St.

State Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 2. Date of Death 1. Decedent'e Neme (First, Middle, Last) 3. Time of Death Month **Physician** 4: 10 4a Facility Name It not institution, give street end number) Gilchrist Center 6601 N. Charles Street IMACher /Medical 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Baltimore Towson If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 1 M 2 □ F Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Days 68 Yrs. 218-26-4819 Director 1-29-31 Marylang Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland NIA Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7 is marked other than "natural", or items 23s or traumstic event, the Medical Example must be a United States 2731 Wegworth Lane 21230 Herrie 23a Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: War Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: "natural", or Specify: White by 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Caton Plumbing + Elementary/Secondary (0-12) College (1-4or 5+) 7th Plumber Heating 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Surname) h and Mental I Henry Schumacher John Ann Elizabeth Sails Pages 1 and 2 should 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 2731 Wegworth Lane Baltimore, Md. 21230 Department of Health reportant: If Nem 27 Beverly Schumacher/Wife 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removel from Stete 6/2/99 Baltimore, Md. Loudon Park Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Eacility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Road d the deeth. Domenter the mode of dying, such as cardiac or respiratory arrest, type of Robert Bobbert  Part1. Enter the disease, or complications that caused the deeth. shock, or heart failure. List only one cause on each line. Approximele Interval Between Onset end Deeth **Physician** /Medical Immediata Causa (Final 15 months concer disease or condition resulting in deeth) 10 **Examiner** Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaase or Injury that Initiated avants resulting in death) Last Dua to (or as a consequence of) xhumaeher 9 physician the burial Physician/Medical Due to (or es e consequence of): 23b. Did tobacco use contributs to the cause of death? Part II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown p 24b. Were autopsy findings aveileble prior to Completed 24a. Was en autopsy completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was casa referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mannar of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: Albar 5 Pending investigation 1 Natural 1 TYes 2 No 2 ☐ Accident Director 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Ť ò Funeral 1) Certifying Physician: To the best of my knowledga, daath occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Certifier edicai (Check only one) 8 10 To the P within 2 To the P 29b. Signatura and title of certified 29c. License number 29d. Dete signed (Month, Dey, Year) 30,1999 may und ey 30. Name and address of person who complated cause wheath (Itam 23a) (Type, Print) Riley Balto md 6701 N. Charles G-BMC 31. Date filed (Month, Day, Near) 32. Registrar's Signature State JUN 0 1 1999 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician **Physician** Month Year Beulah Edna Stickles May 30 1999 11:45 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St. Joseph Hospital Towson Baltimore If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 F May 7 1908 217-20-2068 Director Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow r than "natural", or itema 23a or 28a-f ahov the Wedical Examiner must be notified at MD Baltimore Baltimore 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 1330 Dartmouth Ave. 21234 USA Funeral 12. Was Decedent Ever in U,S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White by 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 6 n/a Manager Restaurant Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be named of Health and Mental William Walter Perry Dora Elizabeth Green 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 Charles W. Stickles/Son 2703 Sarah Lane, Balto., MD 21234 or other 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 6/3/99 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Jessops United Meth. Ch. Cem. Sparks, MD 21. Signature of Fundiral Septice License 22. Name and Address of Facility Lemmon Funeral Home Lowell 23a. Part1. Entècthe diséase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one ceuse on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a co physician and the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. 1050 1es **Physician/Medical** Due to (or as a conse 50 and 950 signed by the a Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 3 Probably TUnknown 1 ☐ Yas 2 ☐ No Division of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed page 2 s certificate 1 Yes 20 No 1 ☐ Yes 2 ☐ No or Attanding Physician; 25. Was case referred to medical axaminer? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Thpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? After 5 Pending Investigation 1 Netural 1 Yes 2 No within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 43

31. Date filed (Month, Day, Year)

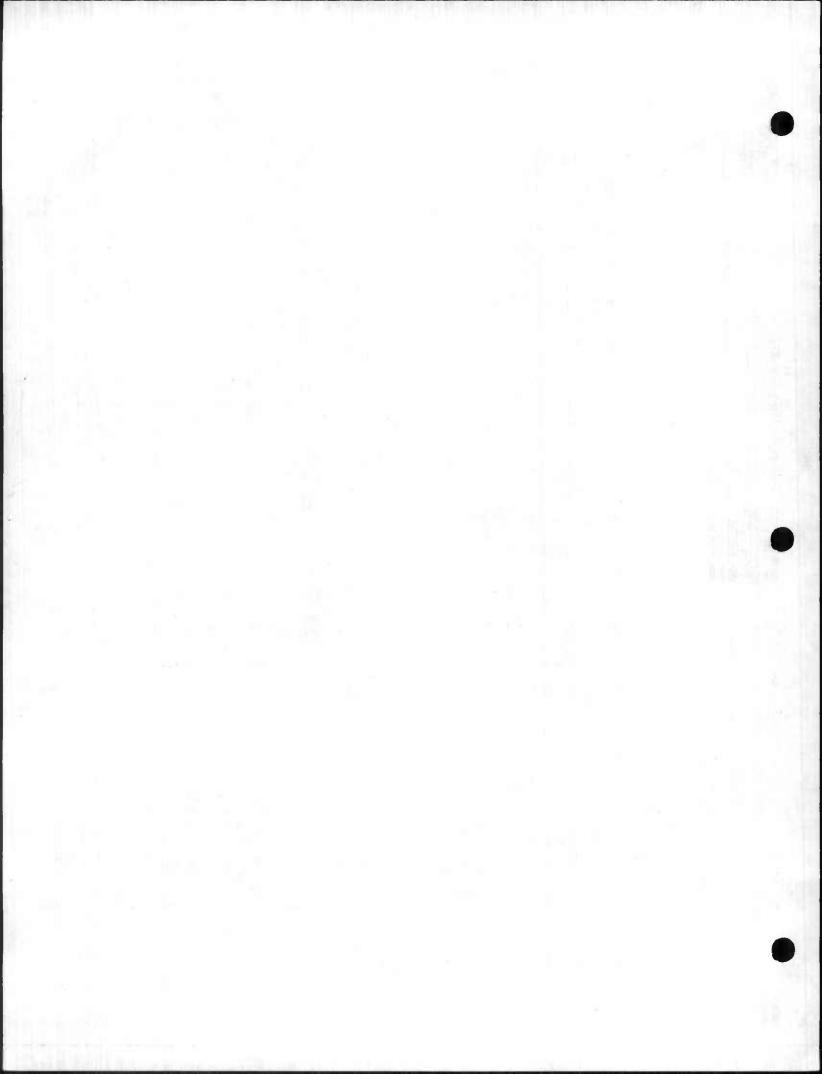
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32. Registrar's Signature



#### Dey 1999 **Physician** 28, John Winand Storke /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner Abingdon 723 Burgh Westra Way If Under 24 Hrs. If Under 1 Yeer 8. Dete of Birth Month Pey, Year) FEB 7, 1936 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Deys Months 10M 20F Hours 63 5hu Norke 5/28/99 12:15 M 219-32-9661 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10e. State 10b. County must be notified at Director Harford Abingdon 10e. Street and Number 10f. Zip Code ss 1 and 2 should be filed within 72 hours after death with of Health and Mental Hygiene. Items 23e or item 2.2 a market and Mental examinations with the Hadical Examination must be other traumatic avent, fire Medical Examination. 21009 723 Burgh Westra Way Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give △ Year or Dates: 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) Coilege (1-4or 5+) District Manager 17. Father's Name (First, Middle, Last) William Sidney Storke Clare Winand 19e. Informent's Neme/Reletionship (Type, Print) Theresa A. Storke/wife 20b. Pieca of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Date Pages nent of h 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State = 8 Metro Crematory, Inc. 5/29/99 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuberal Service Lipes Dawn F. McDonald 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heer failure. List only one cause on each line. **Physician** Immediate Cause (Final diseese or condition resulting in deeth) /Medical Examiner

Approximate Interval Between Onset and Death 23b. Did tobacco use contribute to the cause of death? 12 Yes 2 No 3 Probably 4 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24e. Was en eutopsy

24b. Were eutopsy findings aveilable prior to completion of cause of deeth?

1 ☐ Yes 2 No

26. Piece of Death (Check only one)

1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

31. Dete filed (Month, Day, Year)

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last

1. Decedent's Neme (First, Middle, Last)

5 Pending

28a. Date of Injury (Month, Dey Year)

32 Registrar's Signature

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28c. Injury et Work?

28d. Describe how injury occurred

29a. Certifier (Check only one)

1 Neturel

2 Accident

3 Suicide

4 Homicide

12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the cause(s) end menner es atated.

2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end manner stated.

296 Signature end title of countries

29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

1 1999

MUSPUN

State Registrar

Examiner

Physician/Medical

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Completed

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Certification:

Medical

physician and the burial-trensit

ettending pl for use as t

is certificate has b

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To the Hospital or Attandir within 24 hours after death. To the Funeral Director: At completely filled in by the fu

Attanding Physician:

the death certificate be executed

Division of Vital Records, P.O. Box 68760,

**DHMH 16 Rev 6/95** 

10d. Inside City Limits 1 ☐ Yes 2 ☐ No 10g. Citizen of What Country?

3. Time of Death

9. Birthplece (Stete or Foreign Country) Maryland

12:15 PM

USA 14. Race - American Indian, Black White etc.

White Specify

16b. Kind of Business/Industry

4c. County of Deeth

Harford

Floor Covering

18. Mother's Name (First, Middle, Maiden Sumeme)

2. Dete of Death

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)

723 Burgh Westra Way Abingdon, MD 21009

20c. Location - City or Town, State

Baltimore, MD

22 Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228

CELL LUNG CANCER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Due to (or as e consequenca of)

Due to (or es a consequence of):

Due to (or as a consequence of):

MALNUTRITTON

Investigation 6 Could not be determined

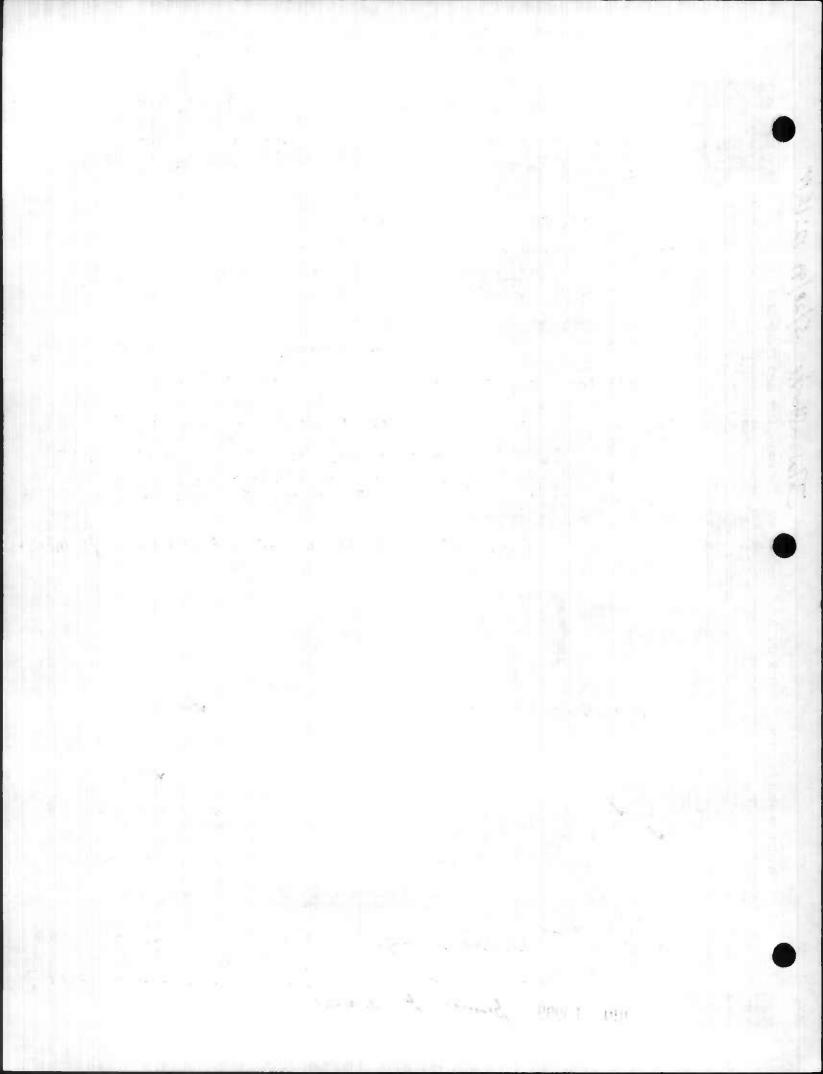
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Other: 4 ☐ Nursing Home 5 M Residenca 6 ☐ Other (Specify)

29c. License number



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month 28 28 1999 MARGARET 6:30 A.M. STROUP 4e Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death GENESIS ELDERCARE - CROMWELL CENTER TOWSON BALTIMORE If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours 1 □ M 280 F MARYLAND 216-14-0291 88 Usual Rasidence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 2 No BALTIMORE TOWSON 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6401 LOCH RAVEN BLVD. APT. 733 21239 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 1 Yas 2 No if Yes, Give Year or Dates: 1 Never Merried 2 Merried 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 8TH GRADE (0-12) College (1-4or 5+) WAITRESS RESTAURANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) EDWARD PRICE KATHERINE RABENAU 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOYCE DIMARTINO DAUGHTER 8724 LACKAWANNA AVENUE BALTIMORE, MD 21234 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stein 4 Donetigh 5 Other (Specify) PARKWOOD CEMETERY 6/1/99 BALTIMORE, MD 21. Signetura of Funerel Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a. Fatf. Enter the disease, or complications that claimed the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death provascular Accident Immediete Cause (Final disaese or condition resulting in deeth) Due to (or as a consequence of):

Physician /Medical Examiner

attending physician and for use es the burial-fran

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has

To the Hospital or Attanding Physician: within 24 hours effer death.

To the Funeral Director: Affer this certification of the funeral director; the funeral director directors dire

Medical Certification: To Be Completed by

The lew requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

**Examiner** 

Funeral Directo

Completed by

Be

MD

**Funeral** 

Director

288-1

23a or

permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene, or frequential it lean 27 is marked other than "natural", or the any injury or other trainmatic event, the Mandred E.

Baltimore, Maryland 21215-0020

Physician/Medical Examiner

	<b>b</b> .							
Sequentielly list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury		Due to (	or as a consequence	e of):				
rasulting in deeth) Last	c.	Due to (	or as a consequence	of):				
	d.		_					
Part II. Other eignificant condition	a cont	ributing to death but not res	sulting in the underly	ring caus	e given in Part I.	2	3b. Did tobacco use co	ntribute to the cause of death?
						24	la. Wes an autopay performed?	24b. Were autopsy findings available prior to completion of cause of death?
25. Was case referred to medical					26. Place of De	eath (Che	ck only one)	
axaminer? 1 ☐ Yas 2 No	He	spitel: 1 Inpatient 2	ER/Outpatient 3[	DOA	Other: 4 ZNursing	-		er (Specify)
27. Menner of Death  1 Neturel 5 Pending 2 Accident invastig	etion	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	- 1355	Injury at Work? 1 Yes 2 No	28d. D	escribe how injury occur	red
3 Suicide 6 Could no determine		28e. Place of Injury - At h building, etc. (Speci	ome, ferm, street, fe	ectory, of	fice	28f. Lo	cation (Street and Numb ly or Town, Stete)	per or Rural Route Number,
		clan: To the best of my know: On the besis of examina and manner steted.						

State Registrar DHMH 16 Ray 6/95

31. Date filed (Month, Day, Year) JUN 1 1999

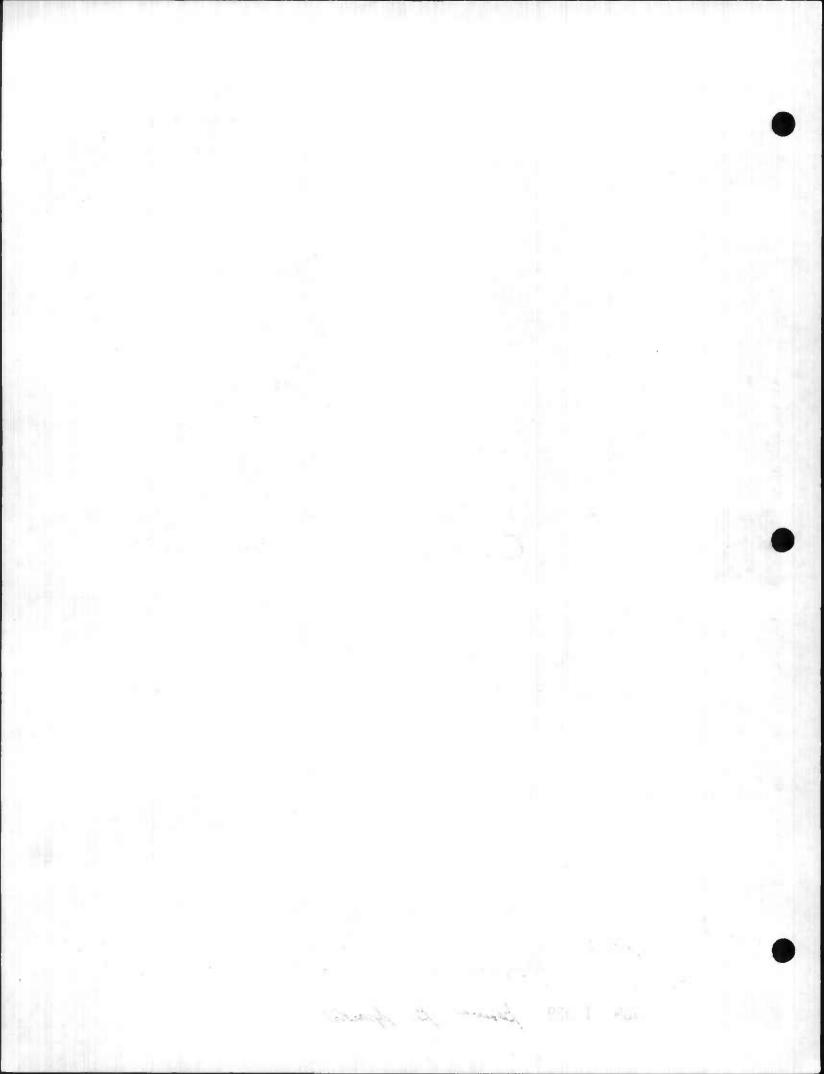
29b. Signature and title of certifier

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 38 Registrar's Signature

Elad Mirza MD

29c. License number

Parkway, Bulkmore, MD21214



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month MAY Physician ANDREW SOPP 29, 1999 10:00 A.M /tiedical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TOWSON BALTIMORE 1602 ABERDEEN ROAD If Under 1 Yaar If Undar 24 Hrs. 6. Data of Birth (Month, Day, Y 1/20/20 9. Birthplace (Stata or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) MM 2DF Months Days Hours Min PENNSYLVANIA 79 202-09-8729 Director **Usual Residence of Decedent** 10c. City, Town or Location 10s. State Phow 10b. County 10d. Inside City Limits BALTIMORE TOWSON 1 ☐ Yas 2 No MD Director 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "netural", or heme 23e or event, the Medical Examinar must be 21286 USA 1602 ABERDEEN ROAD death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ② Yes 2 □ No If Yas, Give Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian. Black, Whita, atc. Pages 1 and 2 ahould be filed within 72 hours effer an ent of Health and Merical Hyglene.
htt: If Nem 27 is marked other than Instural, or Nes in yo other transmitter owns, the Merical Empire in yo other traumatic event, the Merical 1 Never Married 2 Married 1 Yes 2 XNo Specify: Specify. é 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) MEAT CUTTER MANAGER ACME MARKET 12th GRADE Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Be JOSEPH SOPP ANNA MAUSLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MADELINE SOPP WIFE 1602 ABERDEEN ROAD TOWSON, MD 21286 aitimore. 20b. Place of Disposition (Nama of cametary, crematory or other place)
DULANEY VALLEY MEM. GAR. 6/2/99 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cremation 3 □ Removal from State pemil. Page Department Important: If any injury or pose. COCKEYSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euperal Service Licenses 22. Nama and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, 21286 23a Parti. Enter the disease, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onsat and Death Physician nmediata Cause (Final sease or condition sulting in death) /Medical Examiner Physician/Medical Examiner CAPDIOVASCUCAR DISPAFE use as the burlet-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Due to (or as a consequence of) Box P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 Sonknown CORE BRO VASCULAR of Vital Records, ò 24b. Wera autopsy findings Be Completed 24a. Was an autopsy available prior to completion of cause of death? performed? After this certificate has 2KINO 1 TYas 2 TNo 1 Yas apital or Attanding Physician: The hours after death.
neral Director: After this certificate yilled in by the funeral director, pa 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Homa 5 A Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Tima of 28d. Dascribe how injury occurred Division Natural 2 Accident 5 Pending investigation 1 Yas 2 No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide To the Hoepital o within 24 hours at To the Funeral Di Descriffying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and mannar as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and titl ath (Item 23a) (Type, Print) MINWSOHM, M.S. 8813 WAGHAM 88 Michael 2. Registrar's Signature State

**DHMH 16 Rev 6/95** 

Registrar

The state of the state of the state of

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Poris 9:50 AM Townsend MAY 28 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE ST. AGNES HOSPITAL If Under 1 Year If Under 24 Hrs. Birthplaca (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Days 80 Vrs 216-05-5041 Director ct. 06 1918 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow 1 ☐ Yes 2 No Baltimore Catonsville rai', or itema 23a or 28a-f el Examiner must be notified Director Maryland 10a. Streel and Number 10c. Citizen of What Country? 6038 Craigmont Road United States 21228 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Rece - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Guban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married altimore. Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. filed within Elementary/Secondary (0-12) College (1-4or 5+) Own Home Ilth Homemaker 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt.
Department of Health and Mental Hy
Important: If item 27 is marked oth
any Injury or other traumatic event Be may Magee 2 Henry Jerome Meier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Jean Wise/Daughtor Pinetop Glen Burnie, Md. 21061 20c. Location - City or Town, State 1010 Drive 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 6-1-99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Advisor of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Advisor of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Md. 21227 Approximate Interval Between Onset and Death **Physician** Mesenteric I skemia and Bowel Infarction /Medical Immediate Cause (Final disease or condition resulting in death) Examiner fibrillation Atrial physician and s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medicai Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 200 No 3 Probably 4 Unknown Cerebrovascular accident 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 ☐ Yes 2 No 1 Yes Vital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 □ ER/OutpatienI 3 □ DOA of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 ☐ Accident 5 Pending Investigation death. 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

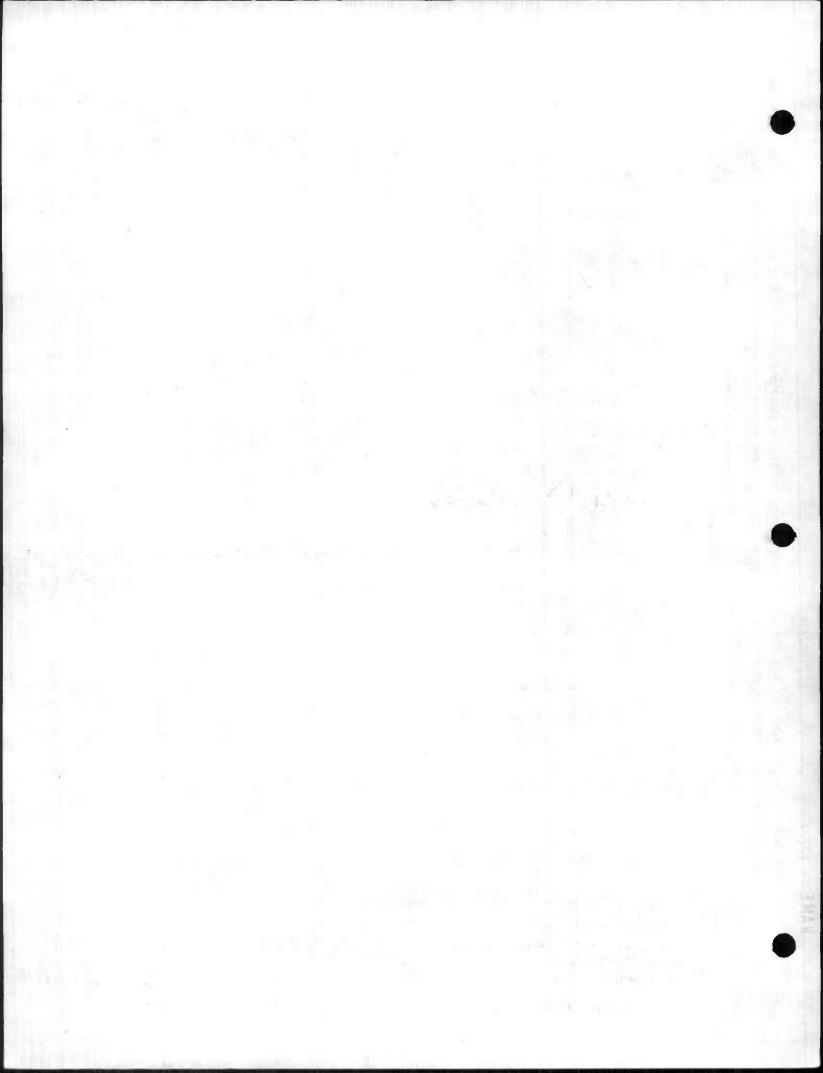
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiel To the Howithin 24 h 29d. Date signed (Month, Day, Year) 29b. Signeture and little of certifier 29c. License number 8228 MAY 28th 1999 KULDEEP SINGH, M.D 900 CATON AUE. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KULDEEP SINGH, DEPT. OF SURGERY, ST. AGNES HOSPITAL, BALTIMORE, MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 0 1 1999 Registrar

DHMH 16 Rev 6/95

TOWNSEND

DORIS

AM



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

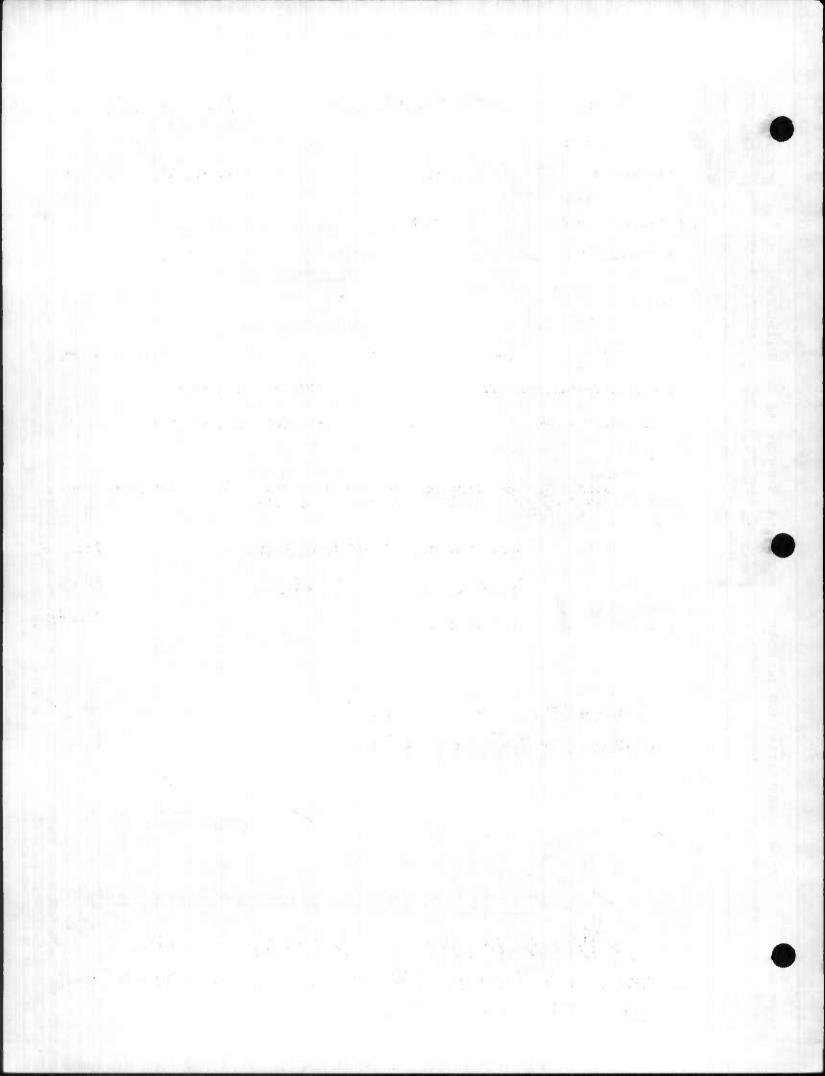
Amende	d#12 perFH G772 6/1/99	EW		Certificate of	Death		Reg. No.	1				
Physician	1. Decedent's Neme (First, Middle, LI GEORGE F. T	RUNK				2. Dete of De Month MAY		ear 4:30 AM				
/Medical Examiner	4a Facility Neme (If not institution, given STELLA MARIS HO				4b. City, Town, or L BALTIMORE	ocation of Deat	4c. County of BALT	Death IMORE				
Funeral Director		Sex 7. Age (In yrs 75		nday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, De Feb. 1						
and show offered at	10a. Stete 10b. County Maryland Baltin		ity, Town	or Location Balt:	imore Cou	nty						
th with the 23a or 28 and be no	10a. Street and Number 5118 Alberta Av	enue		10l. Zip Code	21236		10g. Citizen of Wh. USA	Citizen of What Country? USA				
permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avant, the Medical Engineer must be notified at other.  To Be Completed by Funeral Director	11. Meritel Status  1 Never Married 2 Warried  3 Widowed 4 Divorced	12. Was Decedent Ever in L Armed Forces? 1 ∑ Yes Z¹\s\no If Yes, Give Year or Detes:	mmed Forces?  ☐ Yes, specify Cuban, Mexican, l ☐ Yes, Sive					White, etc.				
be filed within 72 hor tal Hygiene. d other than "natura avant, the Missel Be Completed	15. Decedent's E (Specify only highest gr Elementery/Secondary (0-12) 12 yrs.		- '	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire Ecial Agent	during most of work	ing		BALTIMORE  9. Birthplace (State or Foreign Country)  Maryland  10d. Inside City Limits 1 Ves No  itizen of What Country?  USA  14. Race - American Indien, Bleck, White, etc.  Specify: White  (ind of Business/Industry)  ternal Revenue Ser.  In Sumame)  or Town, State, Zip Code)  yland 21214  Location - City or Town, State  altimore, Md.  Maryland 21236  Approximate Intervel Between Onset and Death  o use contribute to the cause of death?				
should be filed withind Mental Hygiene. I marked other than urnatic avant, the ITO Be Comp	17. Father's Neme (First, Middle, Lass Franz Trunk		, 550	- Jack Higorito		e (First, Middle eilein	, Maiden Sumame)					
1 and 2 sho Health and 1 Am 27 is me ither traums	19a. Informant's Name/Relationship Mark F. Trunk	(Type, Print)		Mailing Address <i>(Street</i> 13 Catalpha								
permit. Pages 1 of Department of He Important: If item any Injury or other pages.	20a. Method of Disposition  1 Durial 2 Cremation 3 4 Donetion 5 Other (Special	Removal from State	cemetery	Disposition (Name of r, crematory or other ple Dod Cemeter		Date -1999		City or Town, State, Zip Code)  Tryland 21214  c. Location - City or Town, State  Baltimore, Md.				
artificate be executed fing physician and se as the buriel-transit												
requires that the death certific seem signed by the attending phould be detached for use as eted by Physician/Med	Part II. Other significant conditions of			ibute to the cause of death								
been sign should be					s en eutopsy ormed?	24b. Were autopsy findings available prior to completion of cause of death?						
certificate has rector, page 2 Be Comp	25. Was case referred to medical	26. Place of Dea		Yes 210 No	1 Yes 2 No							
To the Hospital or Attanding Physician: The is within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page Medical Certification: To Be Com	examiner?  1 Yes 2 X No  27. Menner of Death  1 X Naturel 5 Pending  2 Accident investigatic  3 Suicide 6 Qould not be	00		ome 5 ☐ Res 28d. Describe	idence 6 <b>K</b> Other how injury occurred							
urs after of ral Direct illed in by	4 Homicide determined	building, etc. (Speci	ify)			City or To	wn, Stele)	or Rural Route Number,				
within 24 hours after To the Funeral Director Completely filled in Medical Cert	(Check only 2 Medical Exa	nysician: To the best of my kn miner: On the basis of examin and manner stated.		/or investigation, in my	opinion, death occur		, date and place, an	d due to the cause(s)				
To the common	29b. Signature and Affle of certifier	1(		29c. Licen	43725		_ /	28/99				
750	30. Name and address of person who DR. TARIQ MAHM	OOD 2300 DULA	NEY	VALLEY RD.	TIMONIU	M,MD 21	093					
State Registrar	31. Date filed (Month, Day, Year)	1999 Separa 1999	ature	B. Space	KN							

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a serve to August 1981

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Physician /Medical	1. Decedent's Name (First, Middle, L ERNES	T VAN	MER BU		th O'r Town orlin	2. Date of Death	Pay 1	7799	3. Time of Death		
Examiner	4a Facility Name (If not institution, g	the senier like it.			4b. City, Town, or Lo		4c. County				
Funanal	Lorien Nursing  5. Social Security Number  6.		(In yrs. last birthday	If Under 1 Year	Columbia  If Under 24 Hrs.	8. Date of Birth	Howa		ace (State or Foreign		
Funeral Director	045-20-6280	1□ M 25kF	86 Yrs.	Months Deys	Hours Min.	Oct. 10,	1912	9. Birthplace (State or F Country) New York			
•	Usual Residence of Decedent  10a, Stete 10b, County		10c. City, Town or L	acation				40	ad Incide City Limits		
show				ocation					1 ☐ Yes 2√ No		
with the Maryland a or 28a-f show the notified a	Maryland Howard		Columbia	10f. Zip Code		10	a. Citizen of W	Vhat Count	IV?		
23a or unith	6336 Cedar Lane	. Apt. 116		21044			.S.A.				
items 23	11. Merital Status	12. Wes Decedent E Armed Forces?	ver in U,S. 13.	Was Decedent of I	Hispenic Origin? (Spo en, Mexican, Puerto	ecify Yes or No-	14. Race				
or he	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorcad		0	1 ☐ Yes 2 ☑ No		nican, etc./					
in 72 hours n *natural; noins Ex pleted by	15. Decadent's I (Specify only highest g	rade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	pation during most of work d)	ing 1	6b. Kind of Bu	10d. Inside City Limits 1□ Yes 2€ No of What Country?  ace - American Indien, leck, White, etc. city: white  Business/Industry  opal Church eme)  vn, State, Zip Code)			
d withir giene. or than	Elementery/Secondery (0-12)	College (1-4or 5-	Pri	est			Episco	pal C	hurch		
d oth	17. Father'a Neme (First, Middle, Las	st)			18. Mother's Neme	e (First, Middle, M	eiden Surnem	(e)			
and Mental Hygies armarked other turnstic event, to	Ernest D. Vandeb	n									
12 sh h and h and is ma maum	19a. Informent's Neme/Relationship							State, Zip	Code)		
mit. Pages 1 and 2 should be filled within populment of health and Mental Hygiene. Important: If ferm 27 is marked other than my injury or other traumatic event, the Mental Ment	Lorien Nursing Ho		20b. Pleca of Disp		ne, Colum		21044 0c. Location -	City or Tox	City or Town, State		
permit. Pag Department Important: I any Injury o	21. Signature of Funeral Service Lice Ronald	more	Street								
20260	/ may	10000	B:	altimore,	MD 2120	1		MOTE			
in the same of	23a. Part Enter the disease, or co- shock or heart feilure. List onl	mplications that caused by one ceuse on eech lin	the death. Do not er e.	iter the mode of dyi	ng, such as cardiac	or respiratory erre	st,		Interval Between		
Physician /Medical Examiner	Immediate Ceuse (Finel disease or condition resulting in death)	W	ATION		AIMOI		lakelo.	2			
ě E	resulting in sealing	SWAL	LUWIN	G 0150	RDER			2	WEEKS		
iclan and burial-tran	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or Injury	DEN	Due to (or as e conse	quence of):				17	LYEARS		
cata be executed physician and the burial-transit	Cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting In death) Last	c. Depo	Oue to (or as a conse	quence of):					10150		
ss that the deeth certificate gned by the ettending phys be detached for use as the by Physician/Medic		d									
by the entached for	Pert II. Other algnificant conditions						s 2 No	ntribute to	the cause of death?		
requires that een signed b hould be dete	CUNGRIST			IURE							
	CHRONIL	KRNIT	MALLUI	16		24a. Was an perform		ava	are autopsy findings allable prior to mpletion of cause death?		
hes the pe 2 s							1				
r. page						1 ☐ Ye	-	1	Yes 2 No		
s certificate he director, page	25. Was case referred to medical examiner?	Hospital:	2 DEDO:::	nt 3 DOA Ot	26. Place of Deat	h (Check only one me 5 Resider		or (Casais	4)		
Physician: or this certific eral director, n: To Be	27. Menner of Death	28a. Date of Injur (Month, Day		1		28d. Describe ho			,		
Attending r death. ector: After by the fune iffication	Naturat 5 Pending Investigati		Year) Injury		Yes 2 No						
or Attended in Director do in by the Certific	3 ☐ Sutcide 6 ☐ Could not determine		ry - At home, farm, s (Specify)	treet, factory, offica		28f. Location (Str. City or Town,	eet end Numb State)	er or Rura	I Route Number,		
To the Hospital or Attending Phywithin 24 hours attended the framer of the Funeral Director; Affer thi completely filled in by the funeral completely filled in by the funeral Medical Certification: 1	29e. Certifier 11 Certifying F	Phyaicien: To the best of end manner state	exemination and/or in	th occurred et the tinvestigetion, in my	ime, dete end place, opinion, death occur	and due to the ca red at the time, de	use(s) and ma te and plece,	anner es at and due to	eted. the cause(s)		
within To the comp	29b. Signature and little of dertifier			29c. Chan	se number	29	d. Date signed	d (Month,	Day, Year)		
	· siva	wen	VO	Vo	LTTOT		MH	x 21	) 1999		
	30. Name and address of person who	o completed cause of de	ath (Item 23a) (Type	PAPOLIS	RO EL	LICOTT	ITY M	102	1042		
State Registrar	31. Date filed (Month, Day, Year)	32. Registre	r's Signeture	land.	,						

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene 0

Certificate of Death 1. Decedent'e Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** 8:21 AM MAY Edward Watkins 5 /Medical 4a. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner BALTI MORE HOSPITIAL C17 CENERAL MARY LAND If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number If Under 1 Yeer 7. Age (In yrs. last birthday) Birtholace (State or Foreign Country) **Funeral** 1X M 2 F Months Deys 79 Yrs. 245-20-1682 Director 16, 1919 unknown Usuel Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23s or 28s-f ehow injury or other traumstic event, the Modical Examine: must be notified at 1 Yes 2 No Director Maryland Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1217 W. Fayette Street 21223 U.S.A. Funeral 12. Wes Decedent Ever in U,S.
Armed Forces? unknown
1 □ Yes. 2 □ No
If Yes, Give
Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. pemit. Peges 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or item any injury or other traument. Bleck, White, etc. 11 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Eiementery/Secondary (0-12) College (1-4or 5+) unknown unknown unknown unknown 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be unknown unknown 2 19a. Informent's Name/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) unknown unknown 20b. Placa of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removei from State 4 ☐ Donation 5 ☑ Other (Specify) 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility Wide Director Ronald State Anatomy Board, S. 655 W. Baltimore Street الاند Baltimore, MD 21201 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Deeth Physician /Medical Immediate Ceuse (Finel SEPSIS UNKNOWN diseese or condition resulting in death) Examiner FAILURE Examiner UNKNOWN RESPIRATORY the buriel-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieled events resulting in deeth) Lest Physiclan/Medical Due to (or es e consequence of): 8 jo Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by i 1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 ☐ Onknown þ 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? 24e. Wes en eutopsy Completed performed? 2 10 No 1 Yes 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpetient 3 DOA funeral 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. injury et Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 DNetural Injury 1 Yes 2 No To the Hospital or Attendiwithin 24 hours after death.

To the Funeral Director: A completely filled in by the formal completely filled in the formal complete 2 Accident 3 Suicide 6 Could not be determined 281. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end piece, end due to the ceuse(s) and menner es stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end pieca, and due to the cause(s) end menner stated. edical 29e. Certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signeture end title of certifier P12672 wis of person who completed cause of deeth (Item 23e) (Type, Print) BHUVANBSWARI MARYLAND GENERAL 32. Registrer's Signature

State Registrar

the Maryland

Baltimore, Maryland 21215-0020

certificete be executed

P.O. Box 68760,

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Division of Vital

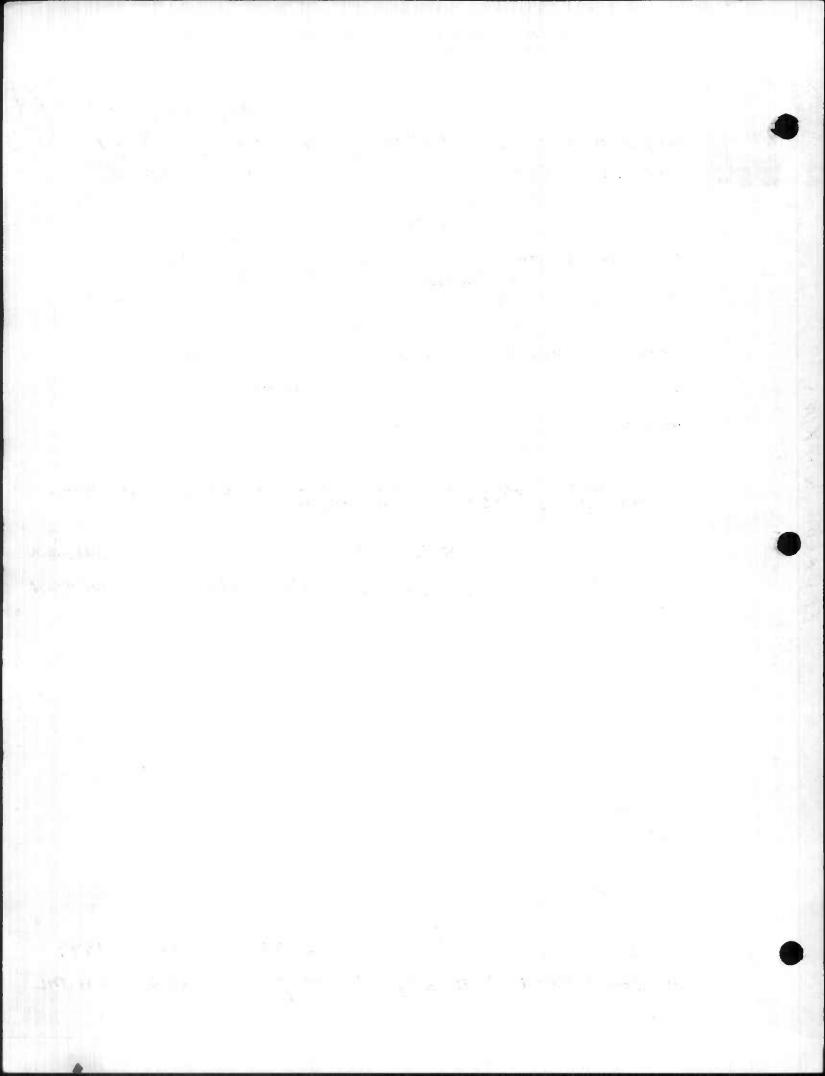
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DHMH 16 Rav 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death **Physician** Z:31 PM 199 26 /Medical or Location of Death 4c. County of Death Examiner If Under 1 Yeer If Under 24 Hrs. **Funeral** Days Director 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Health end Mantal Hygiena. Important: if Ikern 27 le marked other than "natural", or Ikerns 23a or 28a-1 show any Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No **Funeral Director** 10g. Citizen of What Country? 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baitimore, Maryland 21215-0020 2- No þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life., #O NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coilege (1-4or 5+) 100 Father's Name &First, Middle Be Method of Disposition 1 Buriei 2 ☐ Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Micenses 23a. Port . Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting In death) /Medical hr MYSCARDIAL Examiner Due to (or as a consequence of): Examiner 2 R SNARLY if or Attending Physician: The law requiras that the death certificata be associed after death. Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es a consequence of) been signed by the e should be detached f Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3- Probably 4 □ Unknown þ Completed 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an eutopsy performed? certificate 1 ☐ Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Medical Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Deeth 28a. Date of tnjury (Month, Day Year) 28b. Time of Injury 28c. tnjury at Work? 28d. Describe how injury occurred Affar 1 Daturel 5 Pending aftar death.

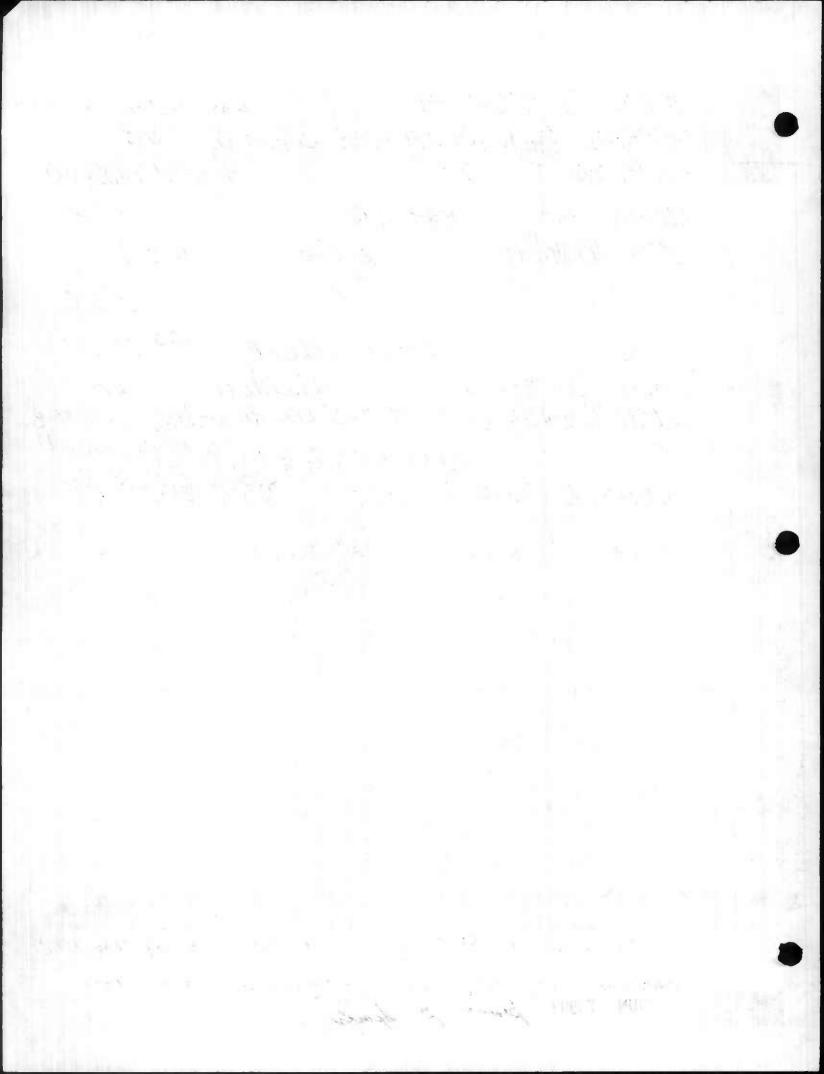
Director: Aft
d in by the fur Investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homictde within 24 hours aff To the Funerei Di completaly filled in 29a. Certifier 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end piace, and due to the cause(s) and manner as stated.

13 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. To the 29b. Signeture end title of certifier 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) MCNABNE 266

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State Registrar

16527



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

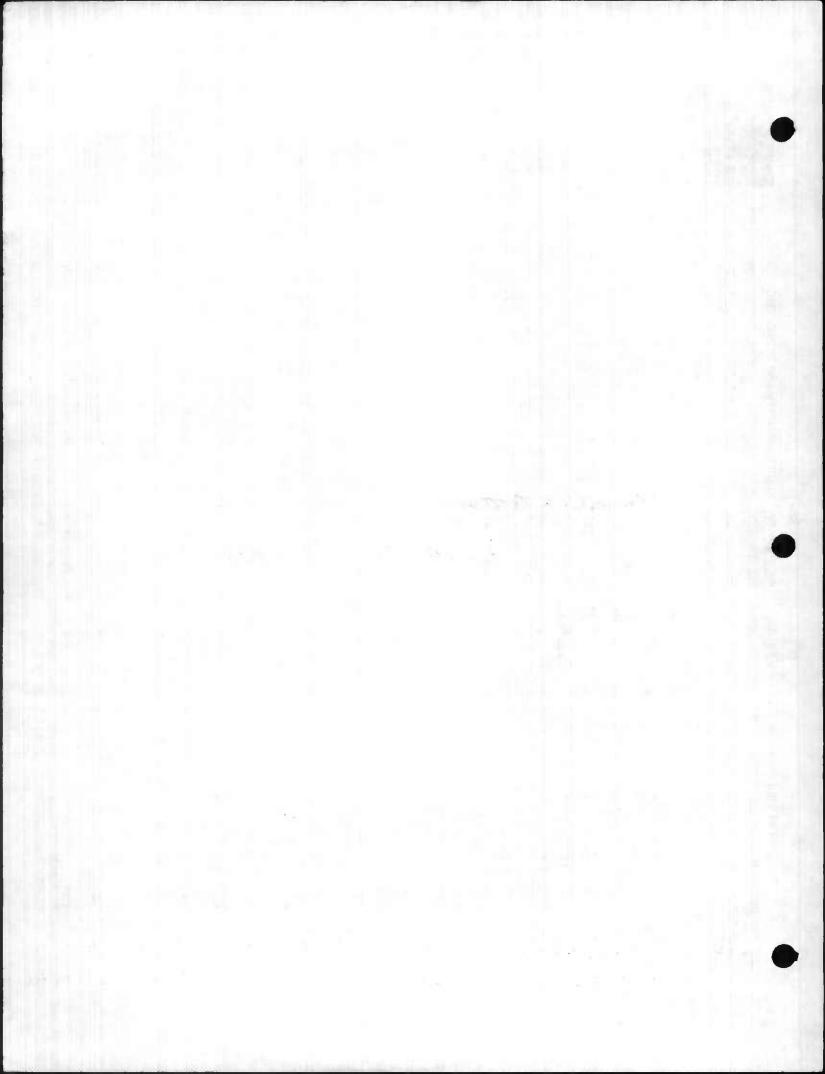
AMEN	DED ITEMS #17 & 18 PE	State of Maryla		ment of F ficate of		Mental Hy	rgiene Reg. No. 99	171.21.					
	1. Decedent's Neme (First, Middle, I					2. Date of De Month	eath	3. Time of Deeth					
Physician /Medical	MILTON	RAYMOND WEG	LEIN			May 2		5:30AM					
Examiner	4a Facility Name (If not institution, g	rive street and number)			4b. City, Town, or L								
	Genesis Hea	Ith Care Homew			Baltimo		N/A						
Funeral Director	218-07-2752	Sex 7. Age (In y		f Under 1 Yeer fonths Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Di October	<sup>1th</sup> Year) 9. 15,1918	Birthplece (State or Foreig Country) Maryland					
and and	Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Local	ion				10d. Inside City Limit					
Many Many Many Many Many Many Many Many	Maryland N/A	F	Baltimore					XIV Yes 2□No					
or 28a-t show be notified at Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	t Country?					
5 0 D	1023 Evesham Ave	nue		21212			USA						
her death r home 23 short must Funeral	11. Marital Status	12. Wes Decedent Ever in Armed Forces?	U,S. 13. We		tispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No		American Indian,					
Example Dy	1 Never Married 2XXX Married	1 XX yes 2 No If Yes, Give Year or Dates:	1959	Yes 2 XX		rical, etc.)	Specify:	White, etc. White					
od within 72 ho yglene. wr than "natur t, the Medical. Completed	15. Decedent's (Specify only highest of	Education prade completed)	16a. Deceden	t's Usual Occup	pation during most of work	kina	16b. Kind of Busine	ess/Industry					
uple Little	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of world)								
	17. Father's Name (First, Middle, La		Ca	ptain	40 Mark ada Nasa	- (Fine stide	Steams  , Maiden Sumeme)	nıp					
Mental H Mental H arked of arked of	Valentine Wegle	· ·	GLEIN				SOPHIA TIE	MAN					
ESEE	19e. Informent's Neme/Relationship Lillie C. Weglein	(Type, Print) Wife	19b. Mailing / 1023 E	Address (Street Vesham	and Number or Ru Avenue Ba	ral Route Numb	oer. City or Town, Stee, Marylan	te, Zip Code) d 21212					
office and	20a. Method of Disposition		. Place of Dispositi cemetery, cremat	on (Name of	00)	Date	20c. Location - City	y or Town, Stete					
2 4 4 5 2 2 2 2 2 2 2 2	1 □ Rurial 2 □ Cremetion 3 4 □ Donation 5 □ Other (Spec	Removel from State		/28/99	Baltimore	. Maryland							
Departm Departm Importa any inju	Gardens of Faith Cemetery5/28/99 Baltimore, Mary  1. Schulture of Funeral Service Licensee  22. Name end Address of Fecility  Mitchell-Wiedefeld Funeral H  6500 York Road Baltimore, Maryland 21212												
	23a. Pert1. Enter the disease or co shock, or heart feiture. List on	mplications that coused the de						Approximate Interval Between					
that the death certificate be executed ed by the stlending physician and deteched for use as the burlet-transit of Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	b. Due to	(or as a consequent (or as e consequent	nce of):  1 6 14 11  nce of):  5 7 8 0 0  nce of):	A ETIVE,			ISCACE.					
strending pl for use as t		d. COMO	ESTIVE	170	ART FA	TLLUK	(=						
deeth e stien ed for u	Part II. Other significant conditions	contributing to death but not	esulting in the unde	rtving cause giv	ven in Part I.	23b, Did	tobacco use contril	bute to the cause of death					
es thet the deeth certificated by the strending be detached for use by Physician/M	PERIPHERA							Probably 4 D-Wiknow					
been should						24e. Wes	s en eutopsy 2 ormed?	4b. Were eutopsy findings evailable prior to completion of cause of death?					
the lev pege 2						10	Yes 21 No	1 Yes 2 No					
certificate rector, peg	25. Was case referred to medical				26. Place of Dea								
Physicien: The lattice the rail director, page 1: To Be Com	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1   Inpatient 2	☐ ER/Outpatient	3 DOA Ot			idence 6 Other (	Specify)					
£ 5 m	27. Manner of Death  1 12 Natural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day Year)		28c. Inju			how injury occurred						
tal or Attending P rs efter death. al Director: After t led in by the funer.  Certification:	3 Suicide 6 Could not 4 Homicide determine	28e. Place of Injury - Albuilding, etc. (Spe	t home, ferm, street cify)	, fectory, office		28f. Location ( City or To	(Street and Number own, State)	or Rurel Route Number,					
To the Heeptal or Attending Is within 24 hours after death of the Funeral Director: After completely filled in by the funeral Medical Certification:	29a. Certifier 1 Certifying F (Check only one)	Physician: To the best of my k aminer: On the basis of exami and manner stated.	nowledge, death or nation and/or inves	ccurred et the ti	ne, date and place, pinion, death occu	, and due to the rred at the time,	cause(s) and manne date and place, end	er as stated. due to the cause(s)					
within To the comp	29b. Signature and title of continer			29c. Licens		~	29d. Date signed (A	Aonth, Day, Year)					
	Spran	eselya		Ds	72228	5	5/27	499.					
	30. Name and address of person wh	o completed cause of death (III)  HALODIYA  32 Aegistrar's Sir	300 7	E. No.	RTHERN	PKW	Y BALTI	MORG 21214					
	111001001100			-			/ /						

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Committee of the commit

	1 Decedentia Name (Circl 4 C.)	o ( act)		Certi	ificate of	Death	l a Deta	Reg. I	Vo. 3 3		3. Time of Death		
Physician /Medical	Decedent's Neme (First, Middle EVA		DES				Moni MAY	h [	Dey 1999	Yesr	12:15 PM		
Examiner	4e Facility Neme (If not institution HEBREW HOME			NGTON		4b. City, Town	n, or Location of ILLE	12	4c. County 10NTG(				
uneral irector	5. Social Security Number 577-03-8311	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs.		If Under 1 Year Months Deys		Hrs. 8. Date Min. (Mon MAR	of Birth th, Day, Yei	913	9. Birthplac Country POLAN	ce (State or Foreign		
B 11	Usuel Residence of Decedent 10e. State 10b. County		10c. Cit	y, Town or Loca	tion					100	I. Inside City Limits		
be notified at Director	MARYLAND MONTG	OMERY	P	OTOMAC							1₽ Yes 2□No		
be notified Director	10e. Street end Number				10f. Zip Code			10g.	Citizen of V	n			
	11505 LEHAVR					UNITED STATE							
by Funeral	11. Maritel Status  1 Never Married 2 Msn 3 Widowed 4 Divorced	if Yes Give	ces? 2. <mark>M</mark> No	If Y	as Decedent of es, specify Cut	oan, Mexicen,	n? (Specify Yes Puerto Rican, et	or No- c.)	Blec	k, White, etc	C.		
	15. Deceden	t's Educetion		16a. Deceder	nt's Usual Occu	pation	of working	16b	Kind of Bu	siness/Indu	stry		
Completed	(Specify only higher Elementery/Secondery (0-12) 12	College (1-	4or 5+)	HOMEM	NOT use retire	ed)	a working		OWN I	HOME			
o Be	17. Father's Name (First, Middle, PHILIP ROSEN			s Name (First, & IE ZELL:		en Sumam	e)						
-	19a. Informant's Name/Relations	or Rural Route	Vumber, Cit	y or Town,	State, Zip C	code)							
Ti de	LINDA HOROWITZ	(DAUGHTI				RE DRIV		-	MARYLAND 20854 Location - City or Town, State ALLS CHURCH, VA.  ION, INC. LE, MARYLAND 20852				
5	20a. Method of Disposition 1 ABuriel 2 ☐ Cremation		tate	Placa of Disposit	tory or other pla		Dete			or Town, State, Zip Code)  ARYLAND 20854  Location - City or Town, Stele			
Injury	4 □ Donation 5 □ Other (S 21, Signeture of Funeral Service		KI	NG DAVI	D MEM.		5/18/	99 F2	ALLS (	JHURCH	I, VA.		
any in	21. Signeture of Fullerial Service												
ician dical niner	23e. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Finel disease or condition resulting in death)		LZH		2'5		=ASE				nterval Between Onset end Death		
Examiner	Sequentielly list conditions, if sny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury C.												
hed for use as the bunal-transit	Cause (Disease or Injury that initiated events resulting in deeth) Lest	с	Due to (o	or as e conseque	enca of):								
for use		_ v								İ			
8	Pert II. Other significent condition	ons contributing to dec	ath but not res	ulting in the und	erlying cause g	iven in Part I.	236	1 Yes	2 DJ NO		he cause of death?		
z should pieted							24a	. Wes en au performed		com	e autopsy findings able prior to pletion of cause eath?		
rector, page 2								1 Yes	200M6	10	Yes 2□ No		
Be	25. Wes case referred to medica examiner?	HospitsI:					of Death (Check	only one)					
T d	1 Yes 2 DHo  27. Menner of Deeth	1 1 1		ER/Outpatient 28b. Time of	3LI DOA		sing Home 5						
To the Funeral Director: After this pompletely filled in by the funeral Medical Certification: 1	1 Oraturs 5 Pendir 2 Accident Investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Placa		Injury ome, ferm, stree		Yes 2 N	28f. Loca	28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route Number, City or Town, State)					
uneral Di sly filled ir cal Cer	29a. Certifier Certifyir	g Physicisn: To the t	pest of my kno	wledge, desth o	occurred et the	time, date end	placa, end due	to the cause	e(s) and me	enner as stal	ted.		
mpletely fil Medical	one)	Examiner: On the bas and mann	er stated.	mon and/or inve			Occurred of the						
2	29b. Signature and title of certifie	//				nse number	501			d (Month, D			
1 1 1	1/1/1009	(uil)	Morpheted cause of deeth (Item 23a) (Type, Print)  L, M·1) - 6121 Morrizose 20, Rockfulle, MD 20852										
9	30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print)												
, (g)	30. Name and address of person	who completed cause	of deeth (Item	23a) (Type, Pr	int)	058 1	20, 2	ock	ulla	MI	D 2085Z		

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

10801 Lockwood Drive #280, Silver Spring, MD

				Ce	lillicati	e or	Dealli		Reg. No.					
Physician /Medical	1. Decedent's Name (First, Middla, Louise C.	Aller						2. Date of E Month May	19 Day		3. Tima of Death 5:05 AM			
Examiner	4a Facility Nama (If not institution, Woodside Center			are			4b. City, Town, o			ounty of Deat				
Funeral Director	578-62-0295	3. Sex 1 □ M 2 □ ▼F	7. Age (In yrs. 103	last birthdey) Yrs.	If Under Months	1 Year Days	If Under 24 Hi	n. (Month, L		9. Birt Co Wash	hplace (State or Foreign unitry) nington, D.			
r 28a-f show inotified at frector	Usual Residence of Decedent     10a. State   10b. County	mery		ty. Town or Lo							10d. inside City Limits 1 X Yes 2 No			
r tems 23s or 28s-f show other must be notified at Funeral Director	10e. Street and Number 9101 Second Ave	nue			10f. Zip	Code 910	E-L			itizen of Whet Country? ted States				
ranhe by Fu	3 Widowed 4 □ Divorced	Armed Fo	s Decedant Evar in U.S. ed Forces?  Yas 2 No ss, Give ir or Dates:  13. Was Decedent of Hispanic Origin? (Sr If Yes, specify Cuban, Mexicen, Puerto Yas, Give ir or Dates:							Race Ame Black, White Afric Decity Ame	a, atc.			
e. had nat	15. Decedent's (Specify only highast Elementery/Secondery (0-12)	Education grada completed) College (1	I-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired) Principal						of Business/	Industry Schools			
d out	William Cornish  Roberta Taliferro													
27 is marke or traumatic	19a. Informant's Name/Relationshi George W. James	p (Type, Print)					end Number or i				Zip Code) 20011			
Department of Health a limportant: if frem 27 is any injury or other tre once.	20a. Method of Disposition  1		State	Place of Disponentery, cre	metory or o ek Cei	mete	ry .	Date 5/24/99	20c. Location - City or Town, Stata					
	21. Signature of Funerel Service Li	22. Name end Address of Fecility McGuire Funeral Service, Inc. 7400 Georgia Ave., N.W. Washington, D.C. 20012  23a. Part First tha disaase, or complications for caused the death. Do not antar the mode of dying, such es cerdiac or respiratory errest, indeval Between Index all Index all Between Index all Index al												
hysician /Medical	Immediate Cause (Final						ng, such es cerdi	ac or respiratory	errest,		Approximate Interval Between Onset and Death			
Examiner	disaase or condition resulting in deeth)	e. Celi	eDue to (or as a consequence of):											
ding physician and ise as the buriel-transit	Conventially list annulitions	■ b. Malı	b. Malnutrition  Due to (or es a consequence of):											
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2 should be									as en autopsy rformed?	1	Were autopsy findings availeble prior to complation of causa of death?			
cate has by page 2 s								10	Yes 2	No	1 ☐ Yes 2 ☐ No			
his certificate il director, pag To Be Co	25. Was cese referred to medicel examiner?	Hospitel:	Inpatient 2	ER/Outpatie	nt 3 DC	Otl	hor:	Home 5 Re		Other (Sne	ocifu)			
6 2	27. Menner of Deeth  1 (Anatural 5 Pending 2 Accident investigation	28a. Dete (Mon	of Injury th, Dey Year)	28b. Time of Injury		28c. Inju Wo	2825	28d. Describ	e how injury o	Idence 8 Other (Specify) how Injury occurred				
25c t	3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Nu City or Town, Stete)  29a. Certifier  1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and													
within 24 hours at To the Funeral D completely filled is	(Check only one)	caminer: On the bi	asis of examination of stated.	ation and/or in	vestigetion	, In my	opinion, deeth oc	curred at the tim	e, dete end pi	lece, and due	e to the ceuse(s)			
To the comp	29b. Signatura and titla of certifier 29d. Dete							9d. Dete signed (Month, Dey, Year) May 19, 1999						
9	30. Neme and address of person w	no completed ceus	e of deeth (Ite	m 23a) (Type,	Print)									

DHMH 16 Rsv 6/95

State

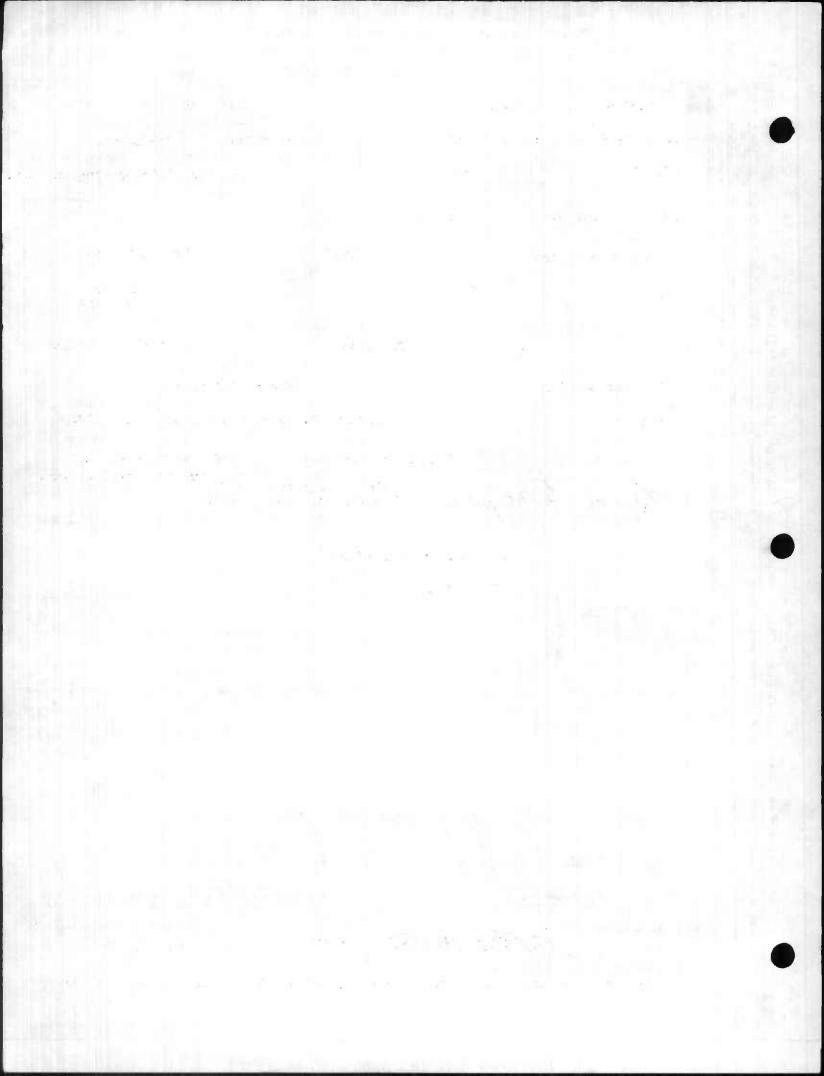
Registrar

Jeffrey P. Indrisano, M.D.

MAY 21 1999

32. Registrar's Signeture

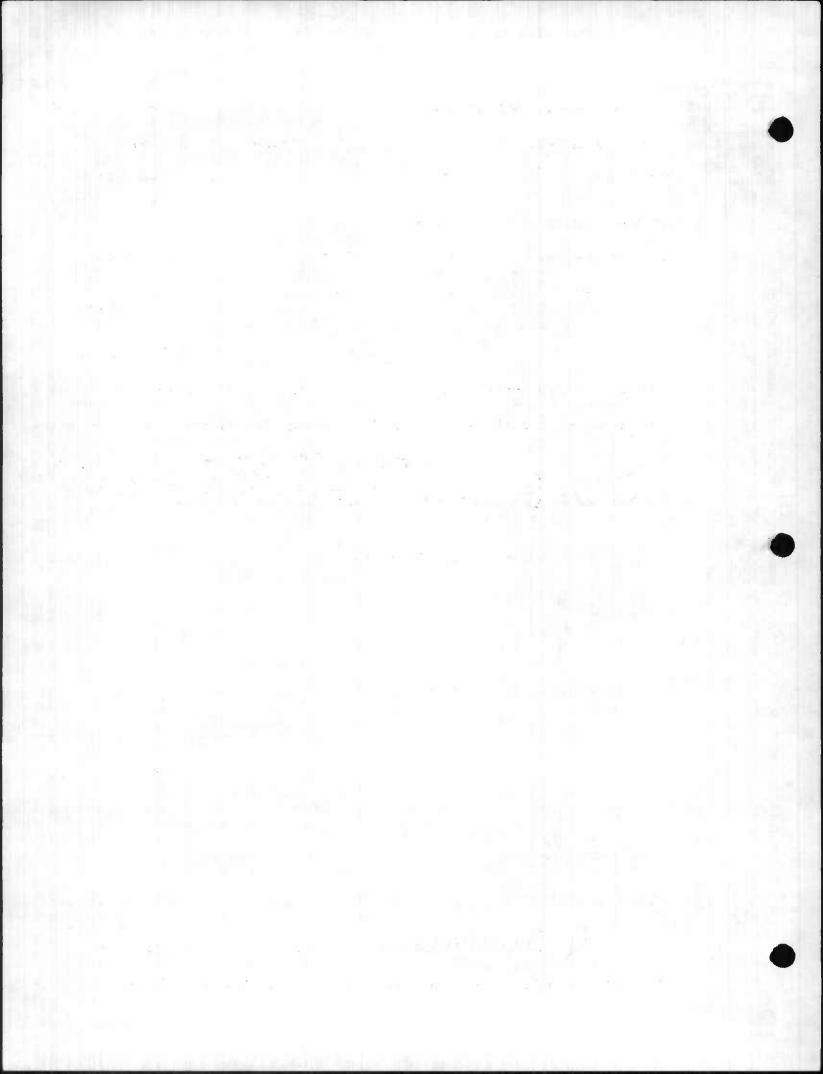
31. Deta filed (Month, Dey, Yeer)



State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 2. Date of Death 1. Decedant's Name (First, Middle, Last) 3. Time of Deeth **Physician** May 13, Stanley Houghton Arthur, Jr. 1999 3:20PM /Medical 4b. City, Town, or Location of Deeth 4c County of Death 4a Facility Name (If not institution, giva street and number) Examiner Montgomery Carriage Hill-Bethesda Bethesda 6. Sex 1 M 2 □ F If Under 1 Yaar If Under 24 Hrs. Hours Min. 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) 5. Social Security Number Birthpleca (State or Foreign Country) **Funeral** Days Yrs Director July 7, 1912 Kentucky 406-09-4931 86 Usual Residence of Decedent the Merylend show 10a. Stata 10c. City. Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Montgomery Potomac 10g. Citizen of Whet Country? 10f. Zip Code 10e Street and Number with 10233 Gainsborough Road 20854 United States Funeral death Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U.S. Armed Forces? LTOX World filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Nevar Married 2 Norried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No War II Specify. Specify: A 3 Widowed 4 Divorced White Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Architect Self-Employed 18. Mother's Neme (First, Middle, Meiden Sumeme) permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: If them 27 is marked oth any linjury or other traumatic event page. 17. Father's Neme (First, Middle, Last) Be 0 Stanley Houghton Arthur, Sr. Margaret Virginia Carter 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 10233 Gainsborough Road, Potomac, Maryland 20 ce of Disposition (Neme of Dete 20c. Location - City or Town, State Mary Thompson Arthur/Wife 20854 20b. Plece of Disposition (Neme of cemetery, crametory or other plece)

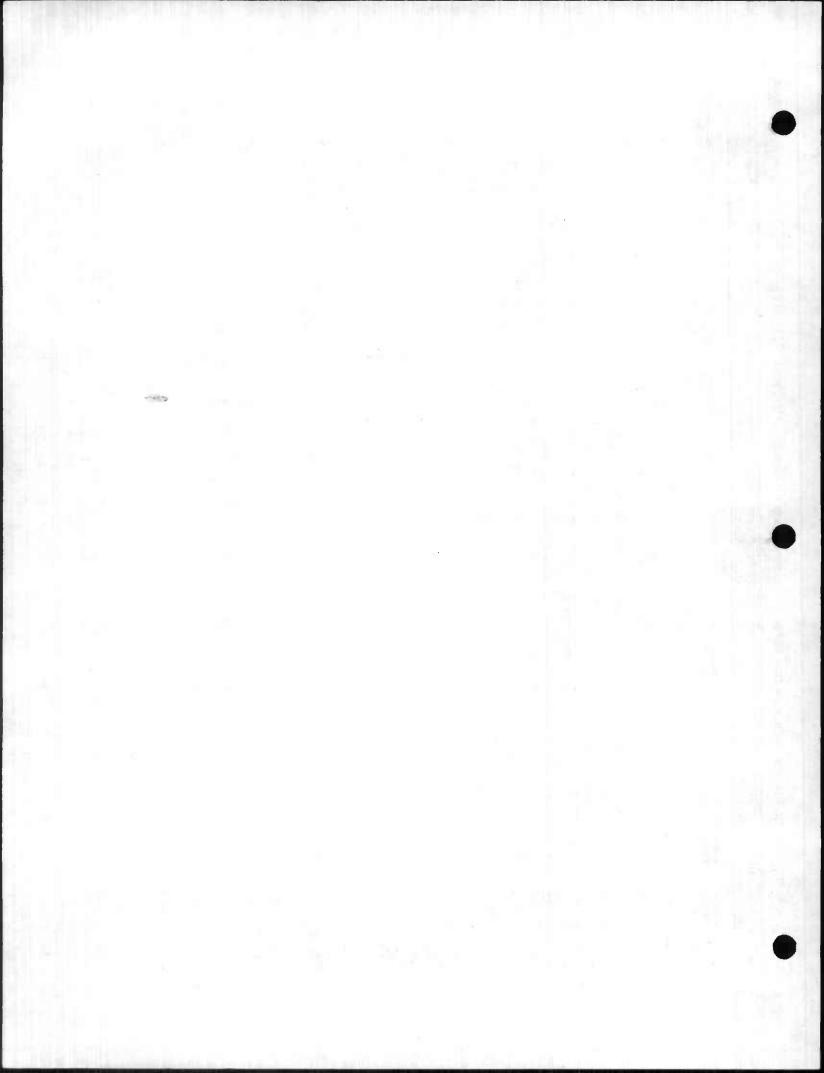
All Hallows Episcopal Church Cemetery May 17, 1999 Davidsonville, MD 20a. Method of Disposition 1 X Buriai 2 ☐ Cramation 3 ☐ Ramoval from State 4 □ Donation 5 □ Other (Spacify) 22. Nama and Addrass of Fecility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. 21. Signature Tureral Service Licens Bethesda-Chevy Chase, Inc. /3 Bethesda, Maryland . M00803 Me 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Aspiration Pneumonia 24 Hours Examiner Due to (or es a consequença of): physician and s the burief-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in deeth) Last Due to (or es e consequence of): certificete be axec Physician/Medical Dua to (or as a consequence of): S, CO use 23b. Did tobacco use contributs to the causs of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. o signed by the 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings svaileble prior to completion of cause of deeth? 24a. Was an autopsy Completed peen paga 2 2XXVIO 1 Yes 2 No 1 □ Yes certificate Division of Vital or Attending Physician: director, 25. Was case referred to medical Be 26. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 2 1 Yes 2 No this funeral 27. Manner of Death 28a. Date of injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred Certification: 28b. Time of After 1 1 Neturel 5 Pending after death. 1 Yes 2 No Investigation 2 Accident 3 Suicida 6 Could not be determined 28f. Location (Streaf and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, offica building, etc. (Specify) filled in by 4 🗆 Homicide 24 hours a Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier To the Hosp within 24 ho To the Fune completely f 2 Medical Examiner: On the basis of examinetion and/or Investigation, in my opinion, deeth occurred at the time, dete end placa, end due to the cause(s) end manner stated. (Check only one) 29b. Signature and title of of ifier 29c. Licanse number 29d. Date signed (Month, Dev. Year) allem D42578 May 14, 1999 +1 20 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) Gul Chablani, M.D. 11119 Rockville Pike, #401, Rockville, Maryland 32. Registrer's Signeture 31. Date filed (Month, Dey, Year) State MAY 18 1999 Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Deta of Death 3. Tima of Death Day Month **Physician** 18, 1999 Victor Anthony Avallone May 6:50 PM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery Care Matrix of Silver Spring Silver Spring 8. Data of Birth (Month, Day, Year) 8. Sax 1 M 2 □ F If Under 1 Year 7. Aga (In yrs. last birthday) 5. Social Security Number Birthplaca (Stata or Foreign Country) **Funeral** Days Months Hours Yrs. 69 Director 578-36-5544 April 28, 1930 New Jersey Usual Rasidance of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show the Medical Examiner must be notified at 1 ☐ Yas 2 No Director Maryland Montgomery Nems 23s or 28s-f Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20910 2700 Barker Street United States death 12. Was Decedent Evar in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puano Rican, atc.) 14. Race - Amarican Indian Black, White, etc. 11. Marital Status filed within 72 hours after 1 Nevar Marriad 2 Married 1 XYaa 2 No If Yes, Giva ò Baltimore, Maryland 21215-0020 1 Yas 2 No If Yes, Giva Yaar or Datas: Unavailable Specify Specify: Completed by 3 ₩ Widowed 4 Divorced White "netural". 16a, Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Hygiene. Elamentary/Secondary (0-12) College (1-4or 5+) Southern Railway Graphic Artist permit. Pages 1 and 2 should be filk Department of Health and Mentel Hy Important: If them 27 is marked other any Injury or other traumatic event. 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumema) Be Anthony Victor Avallone Margarette Lilly Monsini 19a. Informant's Name/Ralationship (Type, Print) (daughter) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 4236 Bordolino Drive, Jeannemarie Avallone-Simerly Chantilly, VA 21051 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location · City or Town, Steta 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stata Chesapeake Crematory 5-19-99 4 ☐ Donation 5 ☐ Othar (Specify) Beltsville, Maryland 21. Signetura of Funaral Sarvice Licenses 22. Name and Address of Facility Rapp Funeral Services, P. A. 933 Gist Avenue, Siler Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final Munya disease or condition resulting in death) Examiner Dua to (or as a consequent Examiner The law requires that the death certificate be executed Sequentielly list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Diseese or Injury that initiated avents rasulting In death) Last and Dua to (or as a consequence of): Box 68760. ettending physician for use as the burle Physician/Medical Dua to (or as a consequence of) P.O. been signed by the e should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Division of VItai Records, by 24b. Wife autopsy findings Completed 24e. Was an autopsy parformed? completion of cause of death? has page 2 To the Hospital or Attending Physician: The within 24 hours after death.
To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1 Yas 2DINO 1 ☐ Yas 2 ☐ No 25. Was casa refarred to medical examiner? Be 26. Placa of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Residence 8 Other (Specify) Certification: To 1 Yas 27 No 2 ER/Outpatient 3 DOA 1 Inpatiant 27. Manner of Death 28d. Dascribe how injury occurred 28e. Deta of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 5 Panding invastigation 1 Netural 1 □ Yas 2 □ No 2 Accident Could not be datarmined 3 Suicida Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Plece of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 Homicida 29a. Cartiflar 1 Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of cartifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) May 19, 1999 30. Nama and addrass of parson who completed causa of death (Item 23a) (Type, Print) 2309 Shorefield Road, D., Wheaton, MD 20902 Myron L. Lenkin, M. 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State Registra MAY 20 1999

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month **JOHN** THOMAS BUCKLEY 1999 MAY 16 10:00 PM /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 5827 RED HILL ROAD KEEDYSVILLE WASHINGTON 5. Social Security Number If Under 1 Yeer If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1⊠M 2□F Days Vrs 229-34-6936 67 JULY 5, 1931 PENNSYLVANIA Usual Residence of Decadent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MARYLAND WASHINGTON KEEDYSVILLE 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 5827 RED HILL ROAD 21756 Funerai U.S.A. 12. Wes Decedent Ever in U.S. Armed Forces? Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 1 XYes 2 No 1951− If Yes, Give Year or Detes: 1959 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No Specify: by Specify 3 Widowed 4 □ Divorcad WHITE Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 PRINTER FEDERAL PRINTING OFFICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) WILLIAM JOSEPH BUCKLEY GERTRUDE SCHUMACHER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5827 RED HILL ROAD, KEEDYSVILLE, MARYLAND 21756 ROSEANN M. HYVARINEN/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burlal 2 □ Cremetion 3 N Removal from State Other (Specify) ARLINGTON NATIONAL CEM. 5/26/99 ARLINGTON, VIRGINIA 21. Signature of Funeral Service Contract 22. Name and Address of Facility 7606 Old National Pike Paul M. Dean BAST FUNERAL HOME Boonsboro, Maryland 21713 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Deeth Immediate Ceuse (Final Acute disease or condition resulting in death) Examiner Due to (or as a consequence of): Chronic Open Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in death) Lest methicillin Resistat Staphylococcus wound infection
Due to (or as a consequence of): Physician/Medicai popilitel stenosis and sugar Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Anticocquistin for prosthetic heat volve 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? Completed 1□ Yes 2 No Covenary artery disease 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) exeminer? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Watural 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Sulcide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the ceuse(s) and manner as stated. 29a. Certifier Medicai (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) and manner stated. 29c. License number 29b. Signeture and title of certifier 29d. Date signed (Month, Day, Year) D0026579 30. Name end eddress of person who completed dayse of deeth (Item 23e) (Type, Print) R. LAWRENCE KUGLER, MD 747 NORTHERN AVENUE, HAGERSTOWN, MD

32. Registrar's Signature

Registrar

State

31. Date filed (Month, Day, Year)

MAY 2 0 1999

**Funeral** 

Director

28a-f show

6 238

Hems

Pages 1 and 2 should be filled within 72 hours after nent of Health end Mental Hygiene. Int If Item 27 Is marked other then "natural", or ite

Department of Health er Important: If Itam 27 is any Injury or other trauonce.

**Physician** /Medical

Examiner

and physician ar

signed by the e

page 2 s

certificete

Hospital or Attending Physician: 24 hours after deeth.
Funeral Director: After this certifice stelly filled in by the funeral director, t

To the Hospital or within 24 hours aft To the Funeral DI completely filled in

that the deeth certificate be executed

Box 68760.

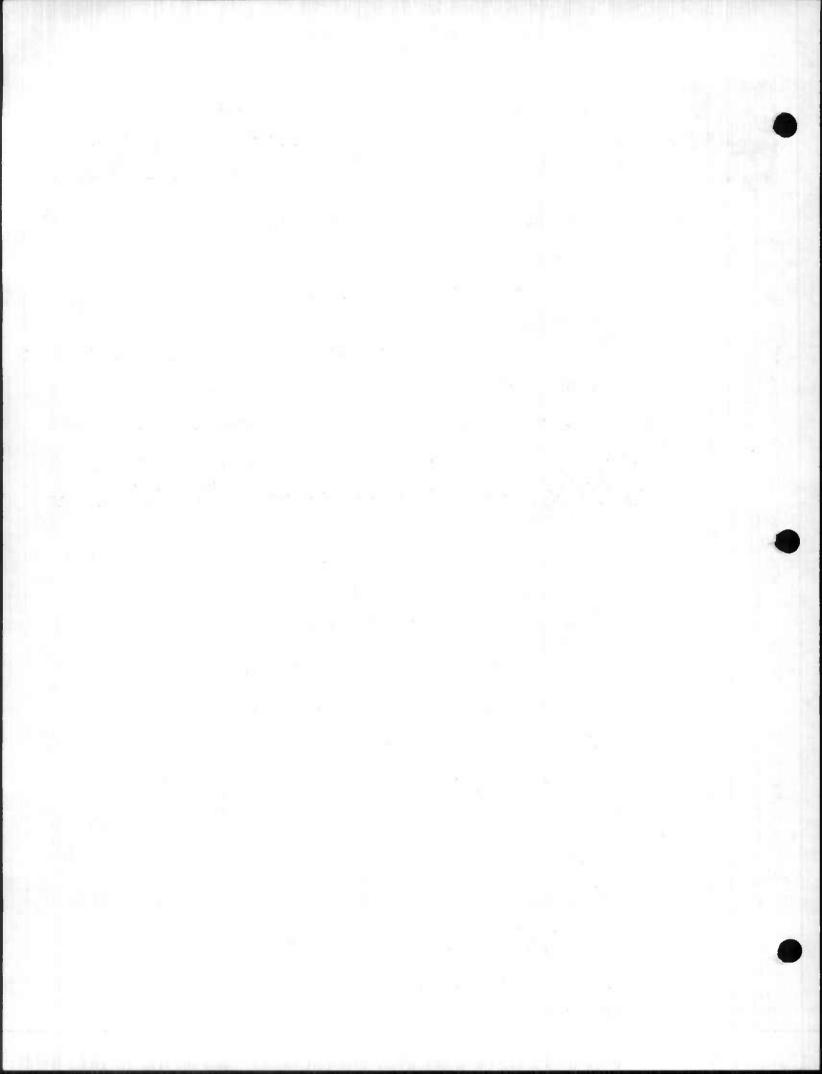
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Records.

Division of Vital

Baltimore, Maryland 21215-0020

traumstic event, the Medical Examiner must be notified at



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5: #23	ART I, 27 PER MEO G772  1. Decedent's Nama (First, Middle, Le			Cortinoc		Doutin	2. Dete of Dea	Reg. No.	3. Time of	Death
hysician							Month May 01	Day	Year 3:37	
/Medical	David Wayne BOW!  4a Facility Name (If not institution, given					4b. City, Town, or		-	1 - 1 - 1	A.M.
xaminer	Washington Coun						stown Washington			
ineral rector	5. Social Security Number 6. S		(In yrs. last b	Yrs. If Und Month:	er 1 Year S Days	If Under 24 Hrs	8. Date of Birt		9. Birthplece (Stete of Country) Maryland	
	Usuel Residence of Decedent  10s. State 10b. County		10c. City. To	wn or Location					10d. Inside Ci	ity Limita
or and					-					2 No
or 28s-/ a be notified Director	Maryland Washing	gron	П	lagersto	ip Code		- T	10g. Citizen of V	Vhat Country?	
0	EEO Tabantus Change					1740		U.S.A		
funeral	558 Liberty Stree	12. Wes Decedent E	ver in U,S.	13. Was Dec	edent of	Hispanic Origin? (5	Specify Yes or No-	14. Rece	e - American Indien,	
Fur Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🛣 N		If Yes, sp	ecify Cut	ban, Mexican, Puer	to Rican, etc.)	Blac	k, Whita, etc.	
b b	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes	21X No	Specify:		Specity	White	
Completed	15. Decedent's E (Specify only highest gr	ducation	16	a. Decedent's Us	ual Occu	pation	dkina	16b. Kind of Bu	sinass/Industry	
omple	Elementary/Secondary (0-12)	College (1-4or 5	+)			during most of wo ed)	nary .			
Con	12	0		Labor	er				ruction	
Be	17. Father's Name (First, Middle, Last	)				18. Mother's Na	me (First, Middle,	Maiden Sumam	e)	
or Health and Men If Nem 27 le marke or other treumatic	Roy Bowers			Genevieve (unknown)						
	19a. Informant's Neme/Reletionship (		19	b. Meiling Addre	ss (Stree	t end Number or R				
	Derik Bowers - S  20a. Method of Disposition  1 Burial 2 XCremetion 3 E		20b. Piace cemel	924 Pen of Disposition (N ery, crematory of	ama of	vania Ave	nue Ha		n, Md. 217 City or Town, State	40
n d	4 Donation 5 Other (Special		Hage	erstown	Crem	atory	5/6/99	Hagerst	own, Maryl	and
Important: eny injury o once.	21. Signature of Funeral Service Lice	nsee	7-	22. Neme	and Addr	ess of Facility	Minnich H	Tuneral	Home	
E 5 8	E. Wilson Blvd. Hagerstown, Mar									
sician edical miner	23a. Part1. Enter the disease, or comshock, or heart failure. List only  Immediate Cause (Final disease or condition resulting in death)	one cause on each line	ing, such as cardia		rest,	Approximati Interval Bet Onset and I	ween			
burlai-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	Oue to (or as a	a consequence of	Ŋ:					
	Cause (Disease or injury that initiated events resulting in death) Last	C.	Oue to (or as a	consequence of	):					
etsched for use as the	Part II. Other significant conditions of	ontributing to death but	t not resulting	in the underlying	cause g	iven in Pert I.	23b. Did 1	obacco usa cor	ntribute to the cause	of death?
be detached by Physic							10	Yea 2□ No	3 Probably 4	Unknown
2 should								en eutopsy med?	24b. Were autopsy available prior to completion of confidents?	findings to causa
							151	/as 2□No	1 □ Yas 2 □	No
ege C	25. Was case referred to medical					26. Place of De	eth (Check only o			
stor, page	axaminer?	Hospitel: 1 Inpatier	1 2 X ER/C	Outpatient 3 1	DOA O	thor			er (Specity)	
director director	1 No 2 No		2.3	ER/Outpatient 3☐ DOA ☐ 26b. Time of Injury		ury at ork?	T	Residence 6 Other (Specify) cribe how injury occurred		
ral director.	27. Manner of Death 1 Netural 5 Pending	28a. Date of Injury (Month, Day	Year)	М		Yes 2 No	281. Location (Street end Number or Rural Route Number, City or Town, State)			
al director.	27. Manner of Death	n Blace of tois	ry - At home,	М	1[				er or Rural Route Nurr	nber,

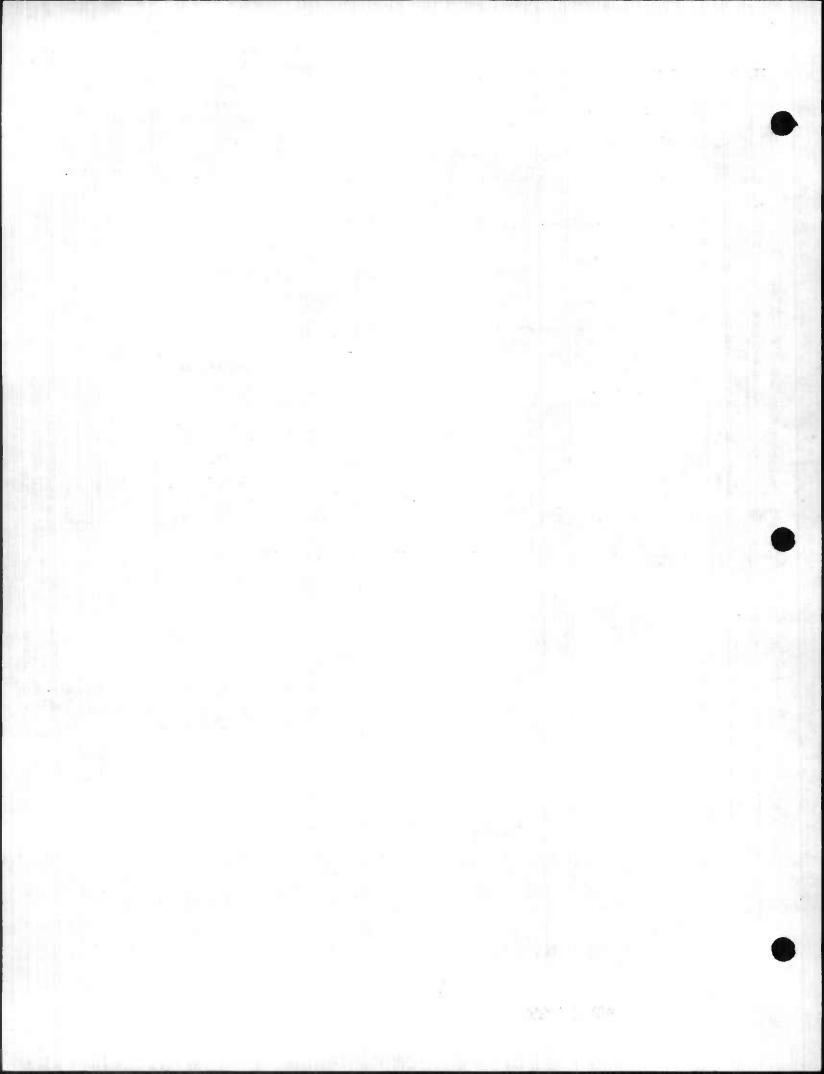
29c. License number O.C.M.E. 29d. Date signed (Month, Dey, Year) May 02, 1999

completed cause of death (Item 23a) (Type, Print) DAVID 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year) MAY 0 6 1999

32. Regisfrar's Signatura

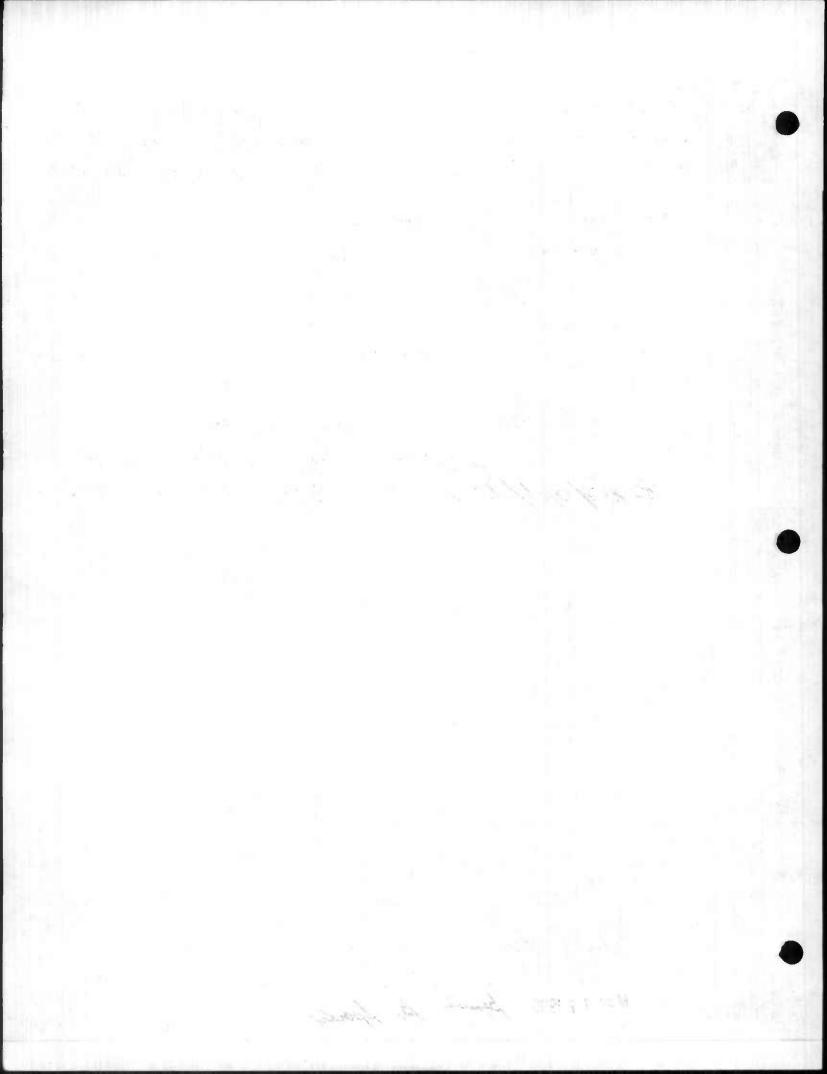


State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** ydia Marie Besse May 16, 0815 /Medical 1999 4a. Facility Name (If not institution, give streat end number) 4b. Clty, Town, or Location of Death 4c. County of Death Examiner Chestertown Nursing Rehab. Center Chestertown Kent 5. Social Sacurity Number If Under 1 Year 8. Date of Birth (Month, Dey, If Undar 24 Hrs. 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign **Funeral** Days 1□ M 2□XF Hours 216-18-2456 Yrs. Still Pand, MD Director 76 13, 1923 Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 415 Morgnec Road items 23a 21620 USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Maritei Status 14. Race - American Indian, Bleck, White, atc. filed within 72 hours after 1 Never Married 2 Married 21215-0020 natural, or 1 ☐ Yes 2 🕱 No Specify: þ White 3 ☐ Widowed 4 X Divorced Specify Completed the Medical 15. Decedent's Education (Specify only highast greda completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry lith and Mental Hygiene. 27 is marked other than "r r treumstic event, the Neo Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing Manufacture Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) . Pages 1 and 2 should be fill ment of Health and Mental Hant: If item 27 is marked oth jury or other traumatic even Mahlon Taylor Ruby Leaverton 19a. informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Deborah E. DiAngelo/Niece 826 Ridley Creek Drive, Media, PA 19063 20a. Method of Disposition

1 □ Surial 2 □ Cramation 3 □ Removal from State 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stata Date permit. Page Department of Important: If any Injury or 4 ☐ Donetion 5 ☐ Other (Specify) Still Pond Cemetery 5/20/99 Still Pond, MD 21. Signature of Funerei Service Licenses 22. Name end Address of Fecility Fellows, Helfenbein & Newnam Funeral Home, P.A. 1.30 Speer Road, Chestertown, MD 21620, confidence that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart fellure. List only one cause on each line. Approximete Onset and Death Physician immediete Cause (Finei disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence of) P.O. Box 68760, Physician/Medical the Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 70 3 Probably 4 Unknown Records, 8 director, page 2 should Be Completed 24b. Were eutopsy findings evailable prior to completion of ceuse of deeth? 24a. Wes en eutopsy performed? certificate has 1 ☐ Yes 2 ☐ No of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was cese referred to medical axaminer? 26. Piace of Death (Check only one) 1 ☐ Yes Other: Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Mannar of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Division 5 Pending investigetion 1 Netural 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, streat, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 24 hours 29e. Certifler 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. To the Hosp within 24 ho To the Fune completely fi 29b. Signature end proof certifier 29c. License number 30. Name end eddress of person who completed cause of deeth (item 23e) (Type, Print) KK 55 516 Weshing In 32. Registrar's Signeture State Registrar



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			1. Decedent's Name (First, Midd	le, Last)								2. Dete of De		-7			me of Death	
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b	nd 2 should be filed lith and Mental Hyg 27 is marked other r traumatic event,	Be C	17. Father's Neme (First, Middle,	Last)							18. Mother's Name	e (First, Middle	, Maider	n Suman	10)			
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ary											nd Number of Rurel Route Number City on Town Asiate, Zip Code)							
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Baltimore,	Pages 1 , sent of He mark If Nem		20a. Method of Disposition 1 🛱 Burlel 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		emovel from		ceme	etery, crem	sition (Name of natory or other panon (	plac	3/10/	1999						
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	o the	Me	29b. Signature and title of certifle	or .					29c. Li	cense	e number	T	29d. De	ete signe	d (Month,	Day, Ye	ear)	
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State Registrar

TED E. HOWE 31. Date filed (Month, Dey, Year) MAY 1 8 1999

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

7542 OVERLOOK 32. Registrar's Signature

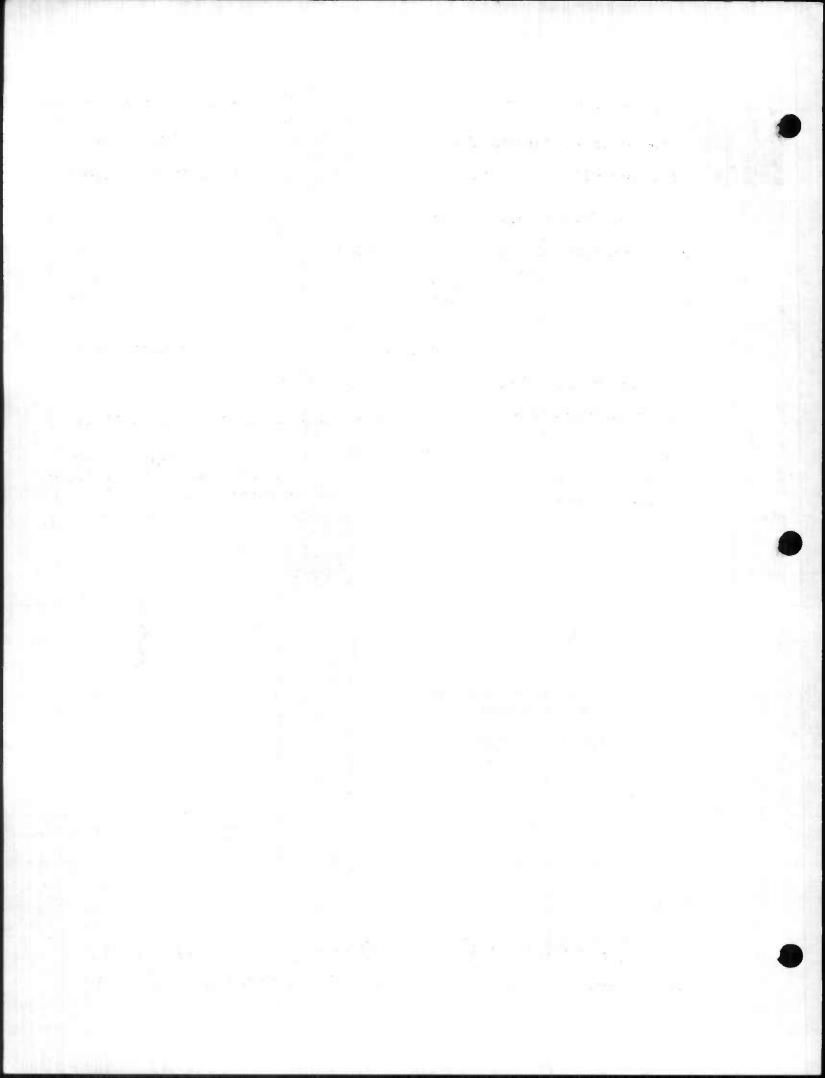
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State of Maryland / Department of Health and Mental Hygiene

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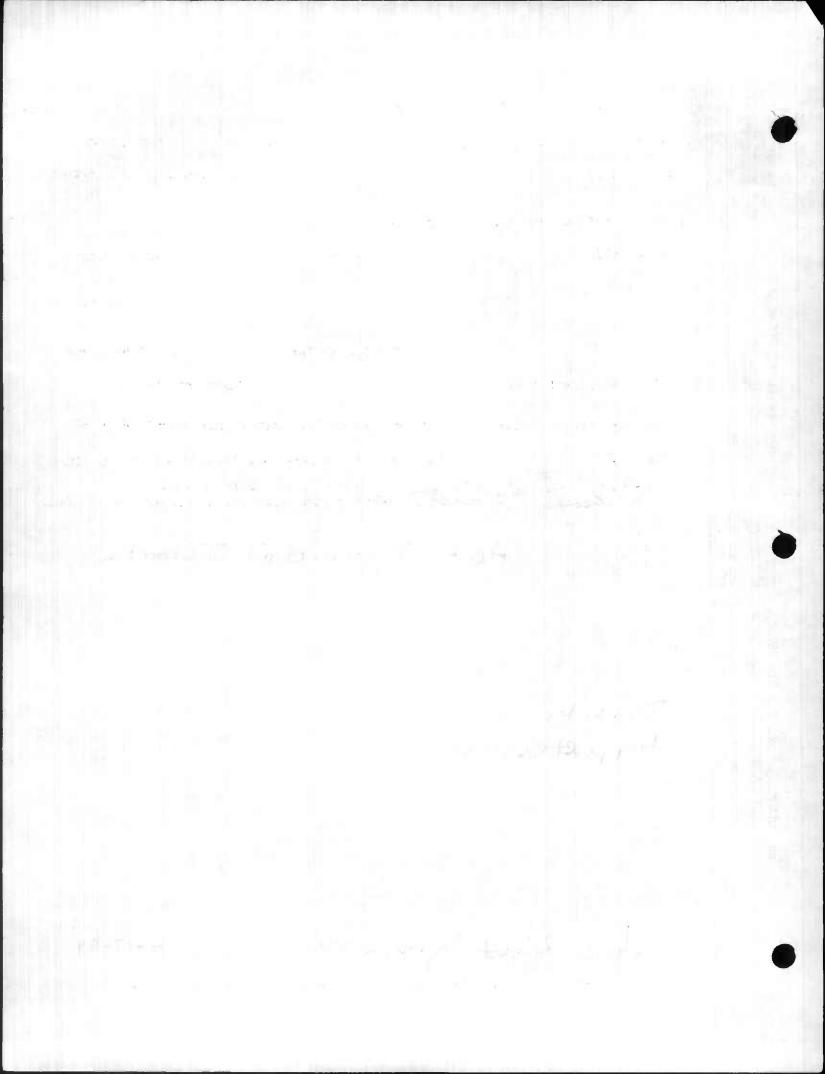
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Month **Physician** ALBERT BETHEL A. May 13 6:44 P.M. 1999 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Yaar If Undar 24 Hrs. 5. Sociel Security Number Birthplaca (State or Foreign Country) 7. Aga (in yrs. last birthday) 8. Data of Birth (Month, Dey, Year) **Funeral** 1⊠M 2□ F Months Days Hours Min 75 579 20 6537 Director June 30,1923 Washington, D.C. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Meryland December of Health and Mental Pyglene.
Important: If item 27 is marked other than "naturel", or flems 23a or 28a-f show any injury or other traumatic event, the Medical Exprines must be notified at page. 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 □ No Maryland Prince George's Directo Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6406 Balfour Dr. 20782 United States Funeral 12. Was Decedant Ever In U,S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-It Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indian. 11. Marital Status Black, Whita, etc. 1 ☐ Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: þ Black. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) EEOC Specialist U.S. Government 18 Mother's Name (First Middle Maiden Sumeme) 17. Father's Name (First, Middle, Last) William Bethel Glendora Parham 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 6406 Balfour Dr., Hyattsville, Maryland 20782 Dorothy Bethel (Wife) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 ☐ Burial 2 MCremation 3 ☐ Removel from State 4 ☐ Donation /5 ☐ Other (Specify) Chesapeake Crematory Inc. 5/18/99 Beltsville, MD. 22. Name and Address of Fecility
McGuire Funeral Service Inc. 7400 Georgia Ave., N.W., Washington, D.C. 20012 reels Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, whear failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Physician Immediate Cause Final disease or condition resulting in death) upcardial Interction /Medical Examiner Examiner The law requires that the death confincate be expound Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events B Due to (or as a consequence of): physician a s the burial-Records, P.O. Box 68760, Physician/Medical that initiated events resulting in death) Last Dua to (or as a consequence of): ed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. signed by t 1 Yes 2 No 3 Probably 4 Unknown p 24e. Wes en eutopsy periormed? 24b. Were autopsy findings aveilable prior to Completed peen ension completion of ceuse of deeth? s certificate hes b director, page 2 s 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital Hospital or Attending Physician: director, 25. Was cese referred to medicel examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of After 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No n 24 hours after death.

Ne Funeral Director: A pletely filled in by the fu death. Investigation 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Streat end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 🖄 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the causa(s) and manner as stated. 29a. Certifier edicai 2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date end piece, end due to the ceuse(s) and manner stated. (Check only one) within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 5-17-99 D38149 424 NOU Sa 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Susan Leggett- Johnson 6525 Belcrest Rd., Hyattsville, Maryland 20782 31. Date tiled (Month, Day, Year) 32. Registrar's Signeture State MAY 18 1999 Registrar



ph 301-295-1264

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

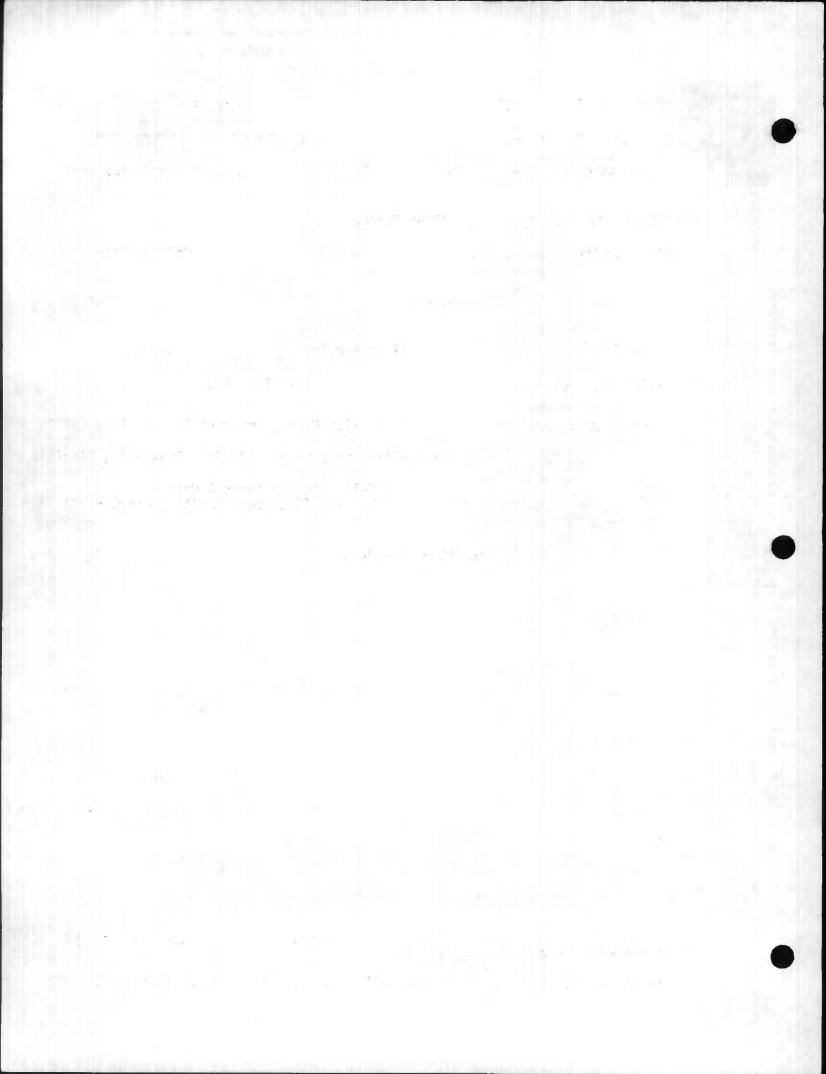
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21215-0020	ors at	3 ☐ Widowed		If Yes, Giva		-	1□Yes 2☑No	Specify:			/:	
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Box 68760,	at the death certificate be executed I by the attending physician and ettached for use as the burial-fransit Physician/Medical Examine	Cause (Disease or that initiated evants rasulting in death) I	injury	c	Due to (or a		equence of):					
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	To the Hospital or Atla within 24 hours after de To the Funeral Directo completely filled in by the	29a. Cartifiar (Check only one)	1⊠ Certifying Phy 2☐ Medical Exam	sician: To the be iner: On the basi and manner	s of examinatio	edge, dea n and/or i	ith occurred at the ti investigation, in my o	ma, date and place, opinion, death occur	and dua to the red at tha time	cause(s) and made and plece,	anner as st and due to	ated. the cause(s)
	Me the	29b. Signature	toto ox darraide	A /	JOHN		29c. Licens	se number	10 N	296. Date signe	d (Month,	Day, Year)
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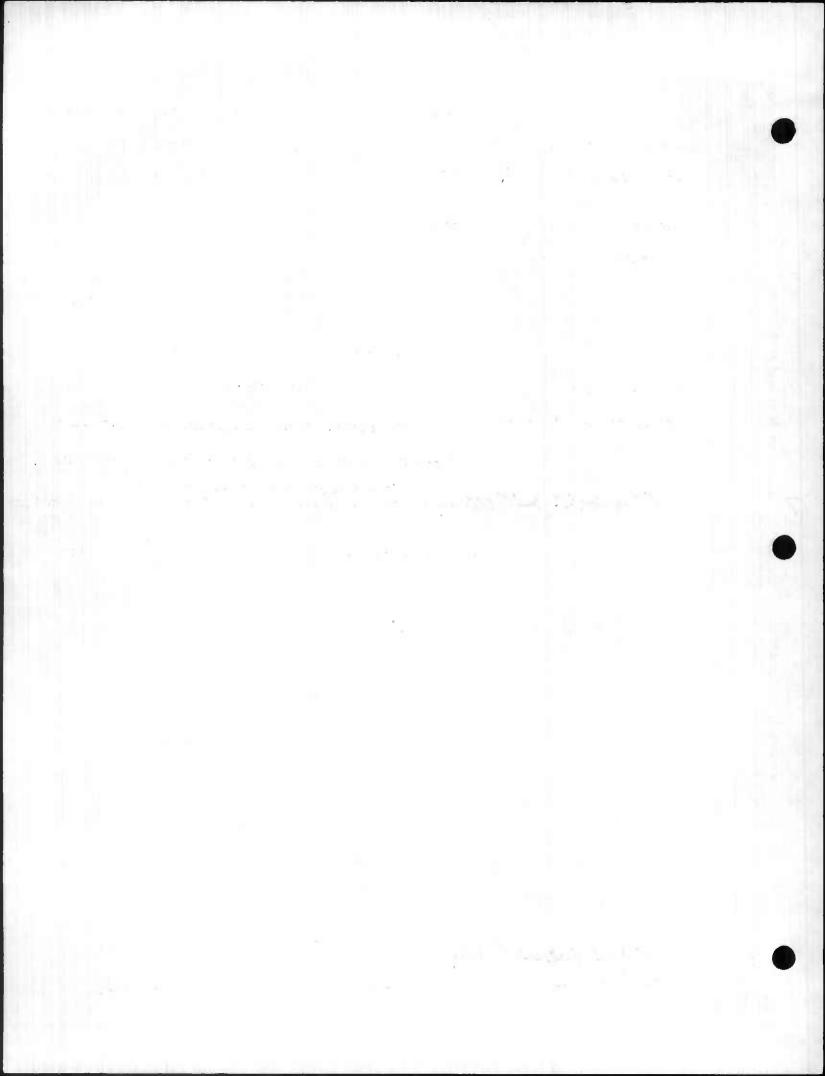
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State of Maryland / Department of Health and Mental Hygiene

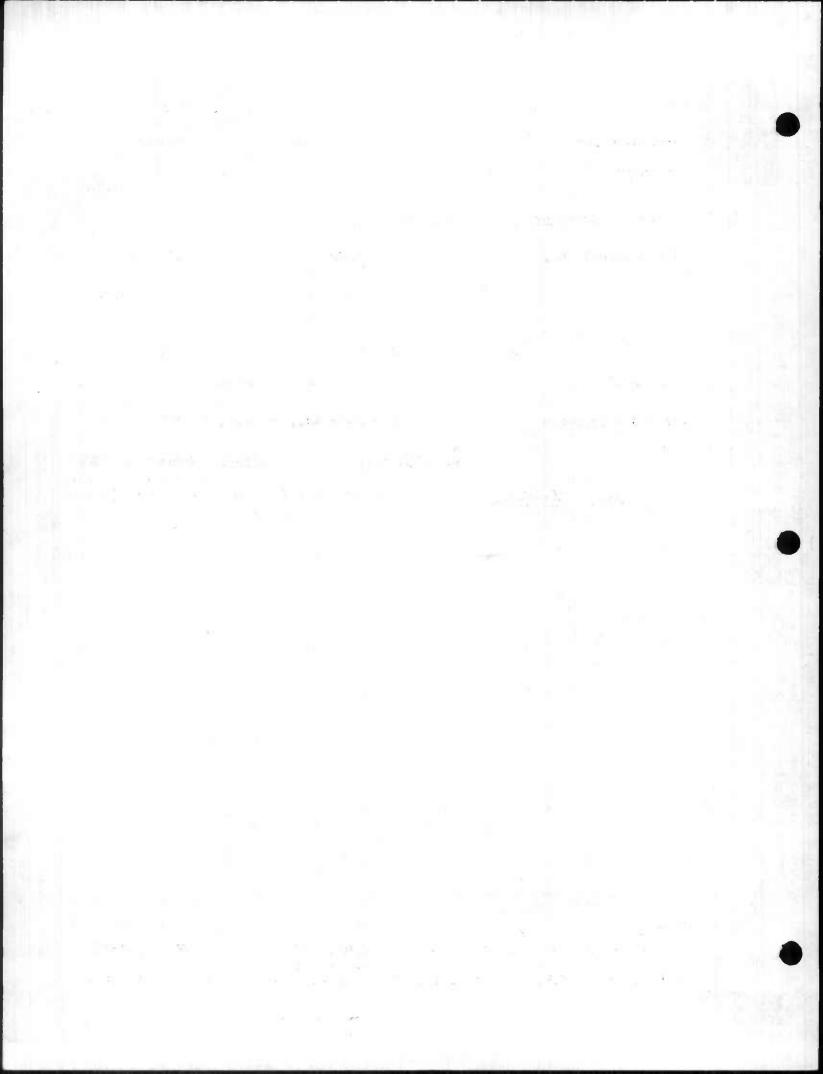
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	Dan-	00	me ll	111		DO	4766			May	20,	19	199	
17	30. Nama and addrass of	arson who	completed cause of d	aeth (Item 23a	(Type Pr	int)								
	Daniel Ros	en b1 ur	n, M.D. 1	0400 Cc		ticut A	ve., S	uite	606 K	ensir	ngton	,Md.	20895	
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legistrar	MAY	133	17 /2		/w ·	KISTU COLLO								



		State of N	larylan				lealth ar Death	nd Menta		ene 9 9	17	437
Physician	Decedent's Nama (First, Middle, L     CELTA	ast)	DDAII	NSTEIN				Me	ita of Death onth	Day 1999	Yaar	3. Time of Death  0:30 A.M.
/Medical Examiner	4a Facility Nama (If not institution, gi	ve street and numbe		NSTEIN		4	b. City, Town	n, or Location		4c. County		V.JV Balle
	Randolph Hills No. 5. Social Sacurity Number 6.	ursing Hom	ne	last birthday)	If Undar		Wheato		to of Righ	Montg		e (State or Foreign
Funeral Director		1□ M 2□F	90	Yrs.	Months	Days		Min. (M.	ta of Birth onth, Day, . 26,	Year) 1908	Country	ylvania
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To Be	Philip Walcoff						Sarah	Raver				
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n ieu	Philip Braunstei 20a. Mathod of Disposition	n – Son	20h P	13005	Pay	son	Street	, Rock		Mary		
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oppo	Demin C	State	7							ion, I		nd 20852
sician edical miner	23a. Part 1. Entar tha disease, or cor shock, or heart feilure. List onf Immediata Ceuse (Final disease or condition resulting in death)		rebrov	vascula	ır Ac	cide					0	iterval Between Insat and Death
the burial-transit	Sequentially list conditions, if any, leading to immediate	J b	Dua to (o	r as a conseq	uanca of):						1	
dicai	cause. Enter Undarlying Causa (Disease or injury that Initiated avents resulting in death) Last	C	Dua to (or	r as a consequ	uance of):						i	
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ache hys	Part II. Other significant conditions	contributing to death	Dut not rasi	uiting in the ur	idenying o	causa giv	en in Part I.	2	1 🗆 Yı			bly 4 Unknown
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completely filled in by the funeral Medical Certification:	1 Natural 5 ☐ Panding 2 ☐ Accident Invastigati 3 ☐ Suicide 6 ☐ Could not	(Month, L	Day Year)	Injury	М		k? Yas 2□N	lo				Routa Number,
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edical		hysician: To the besiminer: On the besis and mannar	of examine									
Me	29b. Signature and title of certifier	1			29		e number		2	9d. Date signe	d (Month, De	ry, Year)
	> SXRI KO	rosla	Un			DO:	9834			May 1	7, 199	19
	30. Nama and eddress of person who											
	Barry Rosenba	um, M. D.	3720 strar's Signa	Farrag	ut A	venu	e, Ken	singto	n, Ma	ryland	20895	
State Registrar	31. Data flied (Month, Dey, Year) MAY 1 9 19		mai a digila	4	1							



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Physician					Month	Dey	Year	
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Examiner		nber)			Location of Death			
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be flied within 72 hours effer deeth with the Maryland of thygiene. A the Hygiene. A control of other than "natural", or items 23s or 28s-f show event, if a Madical Examiner must be notified at Be Completed by Funeral Director.	If Yas, Giv	е			nto Hican, etc.)		YYL	
72 ho		16a.	Decedent's Usuel Oc	cupetion	odkina	16b. Kind of B	usiness/Indusiry	
ne ne mple		-4or 5+)		ired)	Orking			
Hygie Co	17 Father's Name (First Middle Leet)		Owner	19 Mothodo Nic	omo /Elest Middle			
Mental interfect of matic eve	unknown	16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)  Owner  Restaurant  18. Mother's Neme (First, Middle, Maiden Surneme)  Elsie Harrover  19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)  10023 Kendale Rd., Potomac, MD 20854  State  20b. Pleca of Disposition (Neme of complete) park lawn Memorial Park  22. Name end Addrass of Facility Joseph Gawler's Sons, Inc.  5130 Wisconsin Avenue, N.W., Washington, DC 20016  caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory errest, intervel Between Onsai and Deeth  Due to (or es e consequence of):						
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ohysician and the burlet-transit dical Examin	Sequentierly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that hijtstad events.		1				1	
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within 24 hours effective to the European of the Completely filled in Medical Cert	(Check only 2 Medical Examiner: On the bar	sis of examinetion end	, deeth occurred et the Vor investigetion, in m	time, dete end plec y opinion, deeth occ	e, and due to tha curred et the time, d	ause(s) end me lete and plece, o	nner as steted, and due to the car	use(s)
Meithin Fourth	9b. Signature and title of certifiar	1 0	29c. Lice	nsa number	2	9d. Date signed	d (Month, Day, Ye	ar)
36	Muchael 1/8	rody			M	IAY 17	, 1999	
	<ol> <li>Neme end eddress of person who completed cause Michael Grady, M.D., 491</li> </ol>	of deeth (item/23a) ( 0 Massachu	Type, Print) Suit setts Aven	e # 312 ue, N.W.,	Washing	ton, D.	C. 20016	
State Begistrar	11. Dete filed (Month, Dey, Yeer) 32. Re	glstrer's Signeture	1. 1					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Deeth 1. Decedent's Name (First, Middla, Last) 2. Date of Death Month Day **Physician** 5:05 AM 1999 May 16, Alma Elaine Browning /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wilson Health Care Center Montgomery 5 Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF Yrs 98 Director 571-38-8577 Oct. 17, 1900 Missouri Usual Residence of Deceden death with the Marylend 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylen Department of Health and Mentel Hyglene. Important: If item 27 is marked other than "naturel", or items 23s or 28s-1 show any Injury or other treumstic event, the Medical Examinet must be notified at once. 10a State 10h Counts 10c. City. Town or Location 1 Yes 2 No Directo Maryland Montgomery Gaithersburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20877 United States 211 Russell Avenue Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☒ No if Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Mantal Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15, Decedent's Education (Specify only highast grade complated) Elementary/Secondery (0-12) College (1-4or 5+) 12 Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumema) 17. Father's Name (First, Middle, Last) William Sherman Lawrence Viola Tipton 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a, Informent's Name/Relationship (Type, Print) New Market, MD 21774-6144 5767 Woodwind Way, Bernard S. Browning (son) 20b. Place of Disposition (Nema of cematary, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5-17-99 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Beltsville, Maryland 21. Signature of Funerel Service Licensee. 22. Name and Address of Facility Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deat **Physician** /Medical Immediate Cause (Final Proumonitis 3days disease or condition resulting in death) Examiner Due to (or as a consequenca of): Examiner physicien end the burial-trensit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequenca of): that the death certificate be execu Box 68760, Physician/Medical Due to (or as a consequenca of): 80 980 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 2 piabetes mellitus Hypothyroidism signed t Division of Vital Records, à 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en autopsy Completed been Caronary Artery Disease Congestive Heart performed' page 2 1 Yes 2 No 1 □ Yes 2 □ No Farlure certificate or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Hospital To the best of my knowledge, death occurred at the time, dete end place, and due to the ceuse(s) and manner as stated.

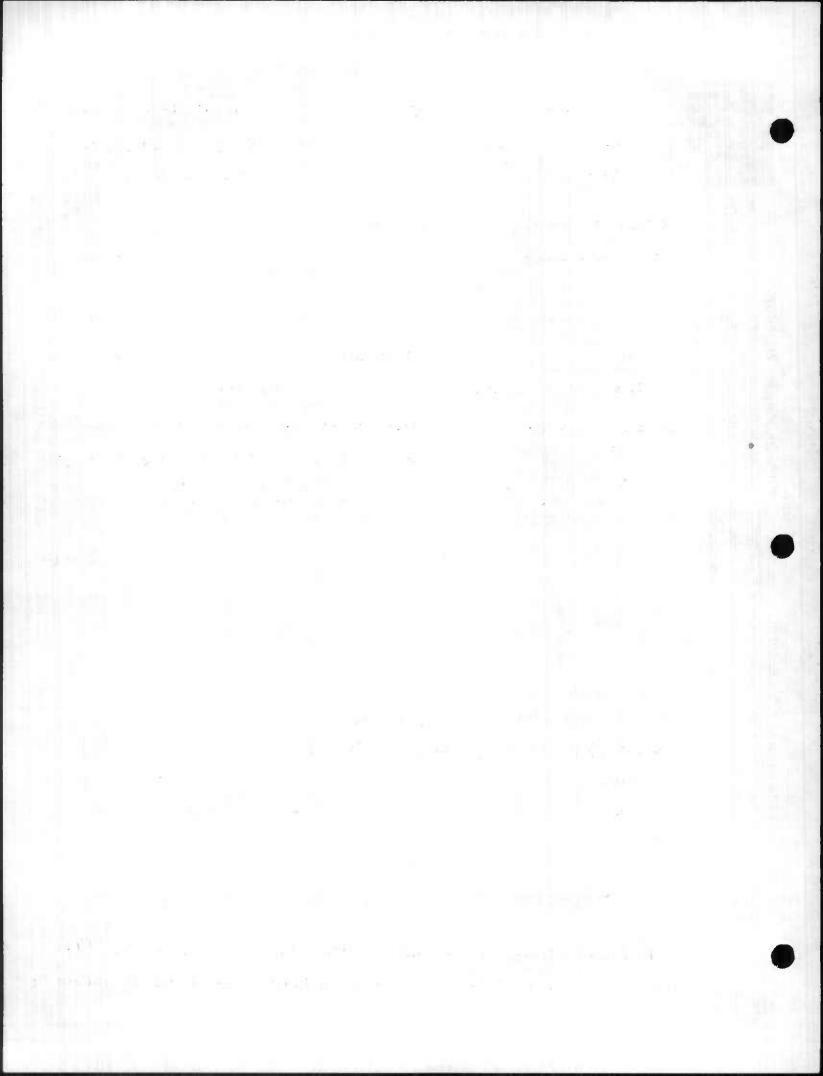
| Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. edical 29a. Certifier completely (Check only one) To the Vithin 2 29d. Date signed (Month, Day, Year) 29b. Signature end title of cartifier 29c. License number may 16, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 041794

911 Russell Avenue Gaithersburg, MD20179

State Registrar Priscilla Callahan - Lyon, MD
31. Date filed (Month, Day, Year)
MAY 1 7 1999
32. Registral

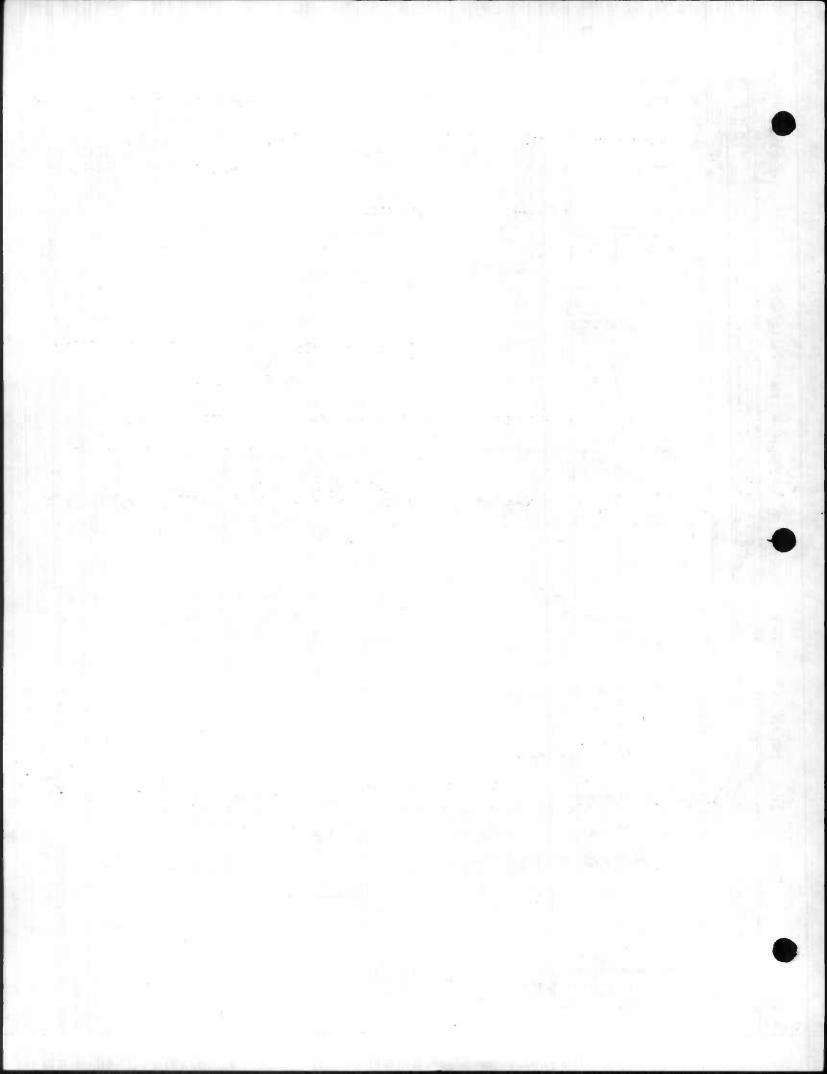
32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene

	1. Decedent's Neme (First, Middle, Last					2. Date of Death Month		3. Time of Death
an :al	JERRY	E. BI	RUNT			May 19	1999	4:20 PM
er	4s Facility Nama (If not institution, give				4b. City, Town, or L	ocation of Deeth	4c. County of	
۹	Montgomery General Security Number 6. Se		yrs. last birthday)	If Under 1 Year	Olney If Under 24 Hrs.	8. Date of Birth	Montgo	
		M 2□F 51	Yrs.	Months Days		Aug. 25	1947	Birthplace (Steta or Foreig Maryland
	10e. State 10b. County Maryland Montgo		City, Town or Lo Brookevi					10d. Inside City Limit
	10e. Street and Number 3501 Sundown R	oad		10f. Zip Code 2083	3		g. Citizen of Whe	
	11. Maritat Status  1 Never Married 2/5 Married  3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Datas:	11	Wes Decedent of I I Yes, specify Cub I ☐ Yes 2 1 No	Hispanic Origin? (Spean, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)		American Indian, Whita, etc. White
	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)			lent's Usuel Occup kind of work done DO NOT use retire TIAN MECha	pation during most of worked)	ing 1	6b. Kind of Busin	c Utility
	12 17. Father's Name (First, Middle, Last)	U	Lillei	nan neen		e (First, Middle, M		c ociricy
		Brunt			Minnie		wes	
	19a. Informant's Neme/Raletionship (T)	ype, Print)	19b. Mailin	ng Addrass (Street	t and Number or Rur	al Route Number,	City or Town, Sta	ate, Zip Code)
	Beverly A. Brunt				Road, Broo	keville.	Maryla	nd 20833
	20a. Method of Disposition  1/8 Burial 2 Cremetion 3 4 Donation 5 Other (Specify)	Removel from State	ob. Place of Dispos cernatary, crem Mt. Carme	netory or other ple	ery 5,			y or Town, State , Maryland
	21. Signature of Funerat Service Licens	Raden	M	Name and Address uriel HO. Box	Barber F			yland 20882
	23a. Pert1. Enter the disease, or comp shock, or heart feilure. List only o	lications thet caused the one cause on each line.	deeth. Do not ente	er tha mode of dyi	ng, such as cardiac	or respiratory arra	st,	Approximata Intarval Between Onset and Death
	Immediate Cause (Finel disease or condition	Vor	frale f	The la	ton			1 how
	resulting in death)	Due	to (or as a conseq	uence of):	7 ( 1			11
		b. Itcc	to for es a conseq	carlel	1htoch	V-	-111	Inou
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	000	10 (01 63 8 001364	46106 017.				
3	Cause (Disease or injury that initiated events resulting in death) Last	C. Due	to (or as a consequ	uence of):				
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I			t resulting in the ur	ndertving cause gi	ven in Pert I.	23b. Did tot	pacco uas contri	bute to the cause of deat
	Part II. Other significant conditions con	ntributing to death but not	t resulting in the ur	nderlying cause gi	ven in Pert I.	23b. Did tot	,	bute to the causa of death
١		ntributing to death but not	tresulting in the un	nderlying cause gi	ven in Pert I.		a 2 No 3	
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State of Maryland / Department of Health and Mental Hygiene

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П	Funeral		5. Social Security Number 6. Sax	M 2 F 7	) Vrs	f Under 1 Year Aonths Days	If Under 24 Hrs. Hours Min.	(Month, Da	rth ay, Year)	Count	lace (State or Foreign
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	yland mt		10a. Stata 10b. Count	10c. City	Town or Local	tion				10	0d. Inside City Limits
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	r dea	Funeral Director		12. Wes Decedent Evar in U,S Armed Forces?	. 13. Wa	s Decedant of H	lispenic Origin? (S en, Maxican, Puarl	specify Yas or No to Rican, atc.)	- 14. Race	e - Amarica k, White, a	an Indian,
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Maryland	sho end h s ma		19a. Informant's Name/Reletionship (Ty	pe, Print)	19b. Meiling	Addrass (Street	and Number or Ru		er, City or Town,	Stata, Zip	Coda)
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ore	of H of H or oth		20e. Mathod of Disposition 1 Magurial 2 ☐ Cramation 3 ☐ R	000	ce of Dispositi natary, cremat	on (Nama of lory or other plac	ca)	Data	20c. Location -		wn, Stata
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mentel Hyglene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Expression and the incited at ODEs.		21. Signeture of Funaral Sarvice Licanse	10	122. N	lame end Addra	ss of Facility	incest the	nn e	•	
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day 1999 **Physician** APRIL 29, Year .IAMES ALBERT BRIDDELL. SR. 4:09AM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 12000 JEFFREY LANE PRINCESS ANNE SOMERSET 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 06/26/1941 6. Sex 1 M 2 ☐ F 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign **Funeral** Hours MARY LAND 216-38-8242 Yrs. Director 57 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumstic event, the Modical Examinat must be notified at 1 Yes 2 No Director MARYLAND SOMERSET PRINCESS ANNE 10e. Street end Number 10f. Zip Code 10g, Citizen of Whet Country? 12000 JEFFREY LANE 21853 USA Funerai 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mentel Hygiene. I mortant: If Item 27 is merked other than "natural", or flee eny Injury or other traumatic event 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) CONTRACTOR **ELECTRICAL & SEPTIC** 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be J. PAUL BRIDDELL ANNIE BLOODSWORTH 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) GAIL M. BRIDDELL/WIFE 12000 JEFFREY LANE, PRINCESS ANNE, MD. 21853 20b. Pleca of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removel from State BEECHWOOD CEMETERY 5/2/99 PRINCESS ANNE, MD. Signeture of Funeral Service Licensee 22. Name end Address of Fecility
HINMAN FUNERAL HOME M00295 11673 SOMERSET AVE., PRINCESS ANNE, MD. 21853 Per1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medicai Immediate Cause (Finel disease or condition resulting in deeth) Examiner Examiner buniel-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Last and Due to (or as e consequence of): physician s the buriel Box 68760 The law requires that the death certificate be Physician/Medicai Due to (or es e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23b. Did tobacco usa contributa to the causs of death? signed by t Aspiration 1 Yes 2 No 3 Probably 4 Unknown þ 24e. Wes en eutopsy performed? 24b. Were eutopsy findings aveileble prior to completion of cause of death? Completed peed r this certificete hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours efter deeth. Funeral Director: After this certifice 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury at Work? Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 D Homicide To the Hospital of within 24 hours of To the Funeral Completely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and piece, and due to the ceuse(s) end manner as stated.
2 Medical Exeminer: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and piaca, end due to the cause(s) end manner stated. 29a. Certifier Medical 29b. Signature and itle of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) oddress of person who completed cause of death (Item 23e) (Type, Print) 22 S. Gryen, St. Balto. MD Do bort

**DHMH 16 Rev 6/95** 

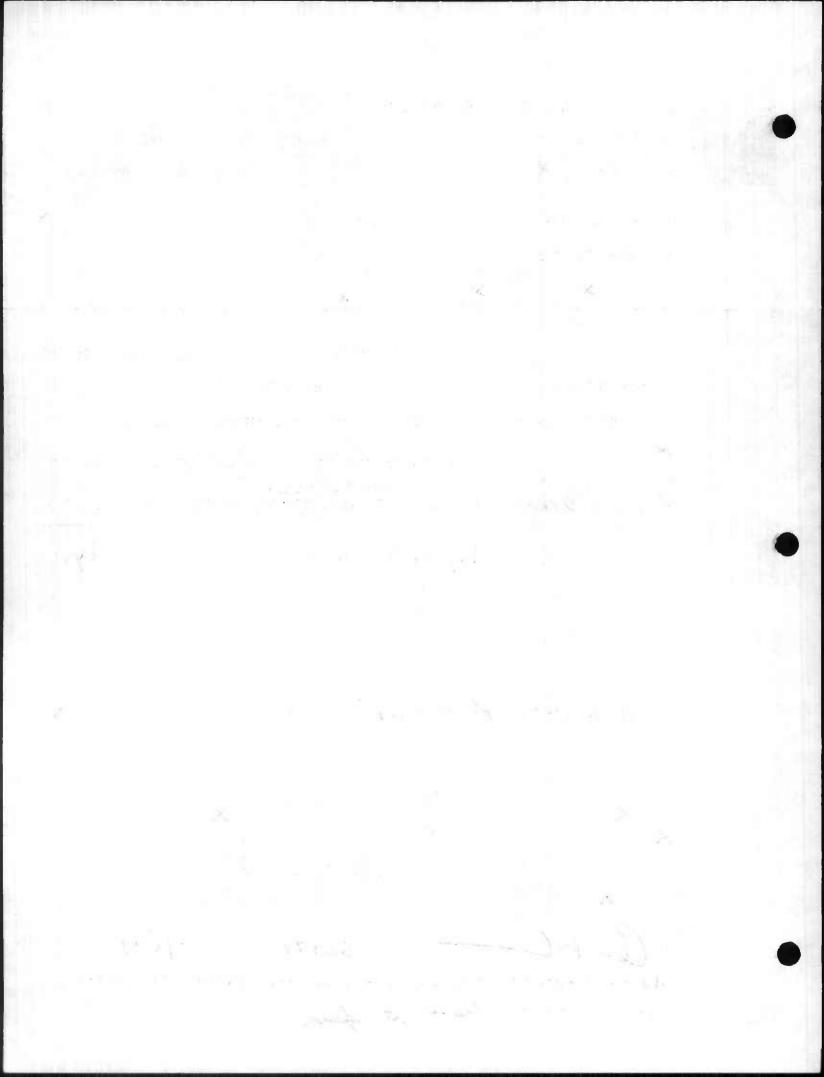
State

Registrar

31. Date filed (Month, Dey, Year)

32. Registrar's Signeture

6 1999



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29e. Certifiar (Check only one)  29e. Certifiar (Check only one)  29b. Signatura and title of pertition  30. Nema and address of parson who Completed cause of deeth (Item 23e) (Type, Print)  29c. Licansa number  29d. Data signed (Month, Day, Year)  31. Date filed (Month, Day, Year)  32. Recistrar's Signature		January, St. (Spacey)				,			
29b. Signatura and titla of contilion  29c. Licansa number  D50987  29d. Data signed (Month, Day, Year)  5/19/99  30. Nema and address of parson who completed cause of deeth (Item 23e) (Type, Print)  HMMLd Maya 2 /05 August 4 Street MD Cambridge 2/16/8  31. Date filed (Month, Day, Year)  32. Recificating Signature	Ca		, daath occurred at	tha tima, data an	d place, a	nd dua to tha car	usa(s) and m	annar as s	itatad.
30. Nema and address of parson who completed cause of deeth (Item 23e) (Type, Print)  Himed Nawaz 105 Aurura Street MD Cambridge 2/16/19  31. Date filed (Month, Day, Year)  32. Registrar's Signature	ed G	one) and manner stated.							
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Registrar

State

Physicia /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiens. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any holivry or other traumatic event, the Medical Examiner must be notified at 805s.

Physician /Medical Examiner

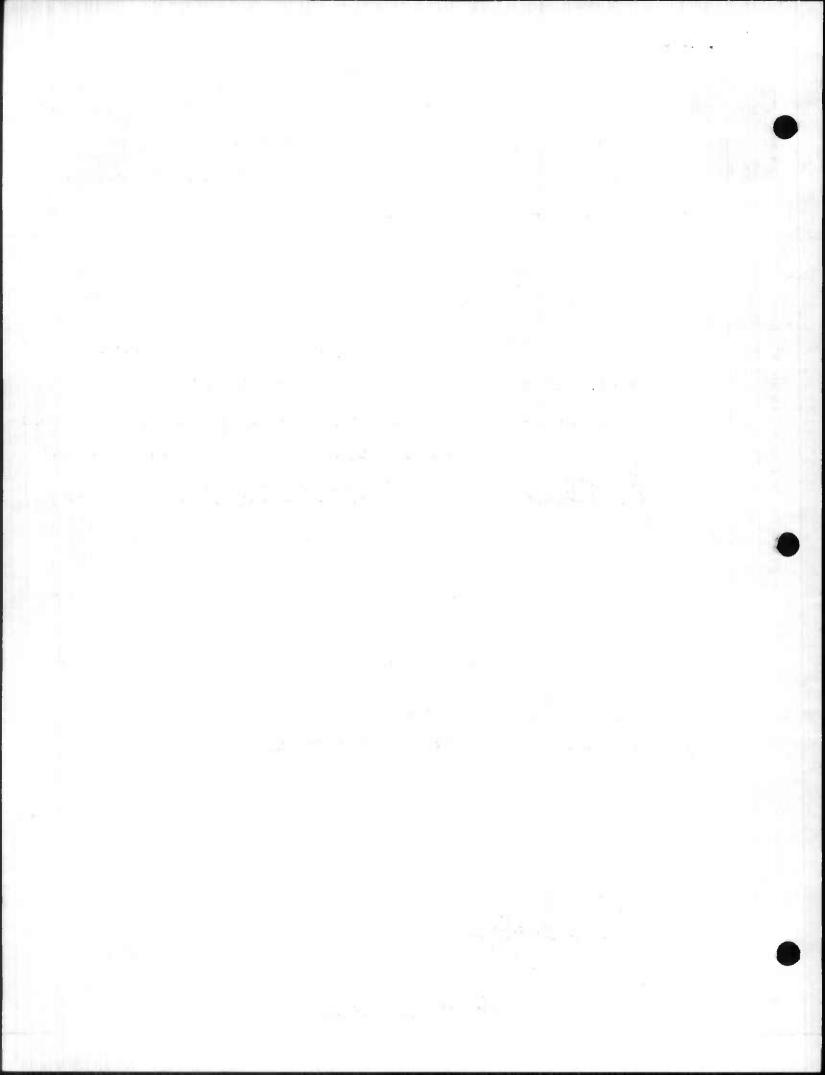
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use es the burial-transit

Division of Vital Records, P.O. Box 68760,

been signed by the attending physician and should be deteched for use as the bunal-transit

Baltimore, Maryland 21215-0020



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	1. Decedent's Neme (First, Middle, Last,	)							2. Dete of Deal	h	W	3. Time of Death
Physician /Medical	CORNELIUS	C. CAF	RTER						May 14	1, Dey 199	9 Year	7:50 PM
Examiner	4a Facility Neme (If not institution, give		•			4	lb. City, To	wn, or L	ocation of Death	4c. County	of Death	
	LAUREL REGIONA	L HOSPI	TAL				LAUR			PR.	GEOF	GES
Funeral Director	210 10 0301	7. A	ge (In yrs. last	Yrs.	If Under Months	Days	If Under Hours	24 Hrs. Min.	8. Dete of Birth (Month, Day Oct. 1	,1924	9. Birthp Cour Ma	placa (Stete or Foreign aryland
e Meryland tarf show tring at	Usuel Residence of Decedent  10a. State 10b. County  MD Anne A	rundel	10c. City, To		ocation aurel						1	0d. Inside City Limits 1 ☐ Yes 2 No
3a or 2a	10e. Street and Number 3527 Spring Ro	ad			10f. Zip (		0724		1	0g. Citizen of V U . S		itry?
2 should be filed within 72 hours after death with the Meryland Mental hydiene. Is marked other than "natural", or ferms 23e or 28e-f show surratic event, the than "natural", or ferms 25e or 28e-f show surratic event, the than "natural" or 10 to 20 completed by Funeral Director	11. Meritel Status  1 Never Merried  Merried  3 Widowed 4 Divorced	12. Wes Decedent Armed Forces 1 XYes 2 If Yes, Give Yeer or Detes:	?  No		Wes Decede	ty Cuba	ın, Mexicar	n, Puerto	ecify Yes or No- Rican, etc.)	Blac	e - Americ k, Whita, :: Bla	
ed within 72 hours ygiene. ner than "natural", rt, tre the office. Completed by	15. Decedent's Edu (Specify only highest grad Elementery/Secondery (0-12)	e completed)		(Give	dent's Usuel kind of work DO NOT use	done d retired	du <i>n</i> ing mos d)		ing	Johns		
Son Con		College (1-4or 12th	1	Bu	ildi	ng						
S S S S S S S S S S S S S S S S S S S	17. Father's Neme (First, Middle, Last)  Cornelius Car	tor							e (First, Middle, I		Θ)	
d Men				Oh 14-11		/C4			e Morga		Ctata Zia	Codel
d 2 sl th and 7 is n	19e. Informent's Neme/Reletionship (T) Lenore R. Cart								Laure			
Heelth Heelth Ism 27 other tr	20a. Method of Disposition	CI (WII	20b. Plece	of Dispo	osition (Nem	e of		day		20c. Location -		
permit. Pages 1 and 2 should be filed within Department of Heelih and Mental Hygeres. Important: If Item 27 is merked other than any Injury or other traumatic avant, the Mace.  To Be Compl	1 ⊠ Burial 2 ☐ Cremetion 3 ☐ F 4 ☐ Donetion 5 ☐ Other (Specify)	1		Zic		urc	h Ce	1.	5/20/99	Laur	el,	MD
Departi Departi Importa any Inju	21. Significant of Funeral Service Ligens	nour	Den	_   S	Neme end NOWD ROCKV	EN	FUNE	RAL	HOME, 20850	P.A.		
Physician	23a. Pert1. Enter the disease, or compleshock, or hear failure. List only of	cetions that cause ne ceuse on eech	ed the deeth. D line.	o not ent	ter the mode	of dyin	g, euch es	cardiac	or respiretory err	est,		Approximate Interval Between Onset and Deeth
/Medical Examiner	Immediate Cause (Final disease or condition resulting in deeth)	50	DDEN Due to (or es	1 C	ARD	PIA	0:	DE	474	4		MMEDIATE
D is of		Cox	Due to (or es	e consec	A D	TP. K	24 1	D15	GASE			10 UYS
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-trensit completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last		Due to (or as	e censed	quence of):							
at the death cartificate be d by the attending physicia etached for use as the bur Physician/Medical	resulting in death) Last	1										
death od for sicis	Pert II. Other algnificant conditions cor	tributing to death	but not resulting	g in the u	inderlying ca	use giv	en in Pert	1.	23b. Dld to	bacco use cor	ntributa te	the cause of death?
v requires that the de been signed by the should be detached leted by Physic									1 □ Y	2 D No	3 Pro	bebly 4 Unknown
The law require sate has been signate has been signate 2 should be Completed the compl	,								24a. Wes a perform		av co	ere autopsy findings allable prior to impletion of cause death?
The law ate has page 2									1 🗆 Y	s 20 No	1[	Yes 24No
	25. Was case referred to medical						26. Place	e of Deet	h (Check only on	e)		
Physician: this carifica and director, part of the Cor. To Be Cor.	axaminer? 1 Yes 2 No	lospitel: 1 Inpat	ient 200 ER/	Outpatier	nt 3 DO	A Oth	er: 4 N	ursing Ho	me 5 Reside	ence 6 Oth	er (Specil	<b>y</b> )
ath. r: After the funera	27. Manner of Deeth  1 Noturel 5 Panding 2 Accident Investigation	28a. Dete of Inj (Month, De	ury By Year) 28t	b. Time o Injury	M 28	Sc. Injury Work	yet k? Yes 2□	No	28d. Describe ho	ow Injury occurr	red	
tal or Attanding P rs after death. al Director: After i ed in by the funer Certification:	3 Suicide 6 Could not be 4 Homicide determined		ijury - At home, tc. (Specify)	, ferm, str	reet, fectory,	office			28f. Location (Si City or Town		er or Ruru	al Route Number,
To the Heaptal or Attending Physician: whin 24 hours after death To the Funeral Director. After this certific completely filled in by the funeral director, Medical Certification: To Be (	29a. Certifier 1 Certifying Physical Check only one)		of examinetion									
Vithin Comp	29b. Signeture end title of certifier	MD		L			275	5-		9d. Dete signed May		
("	30. Name and address of person who con CHRISTINE DE	mpleted cause of	deeth (Item 23s	a) (Type,	Print)	SEI	RI RI	り歩	260 La	urel, N	10.	20707

State Registrar

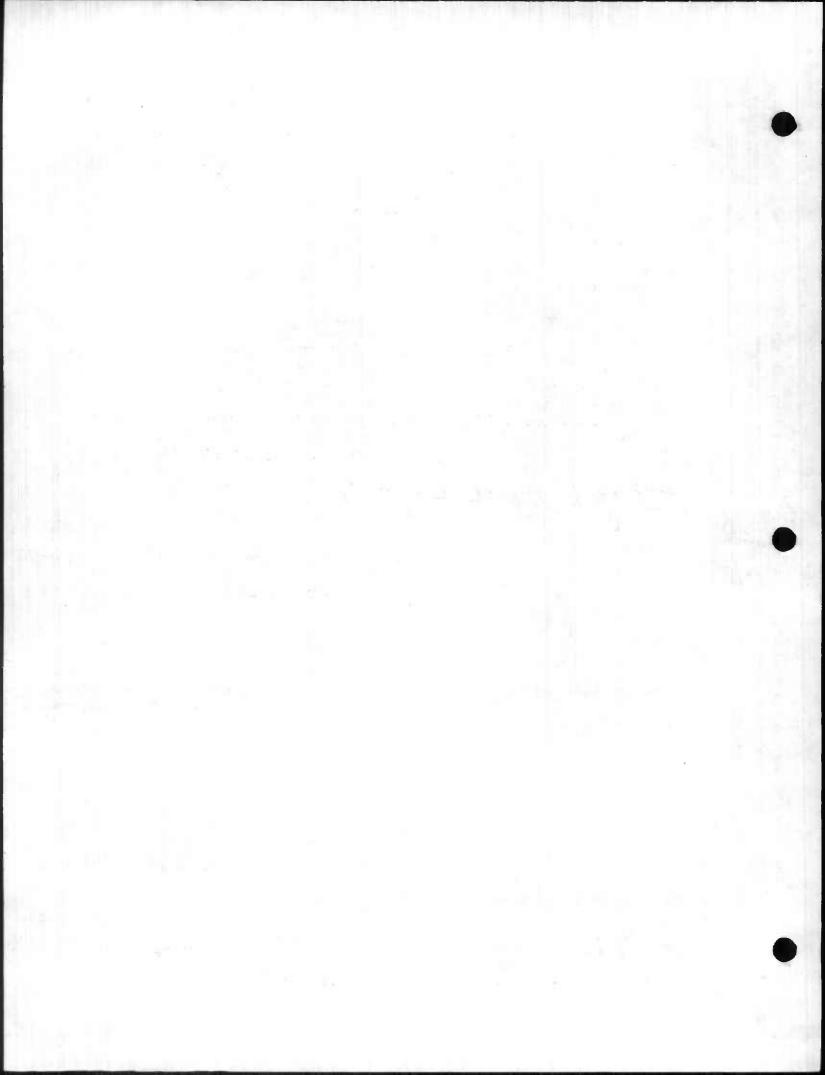
MAY 18 1999

31. Dete filed (Month, Dey, Year)

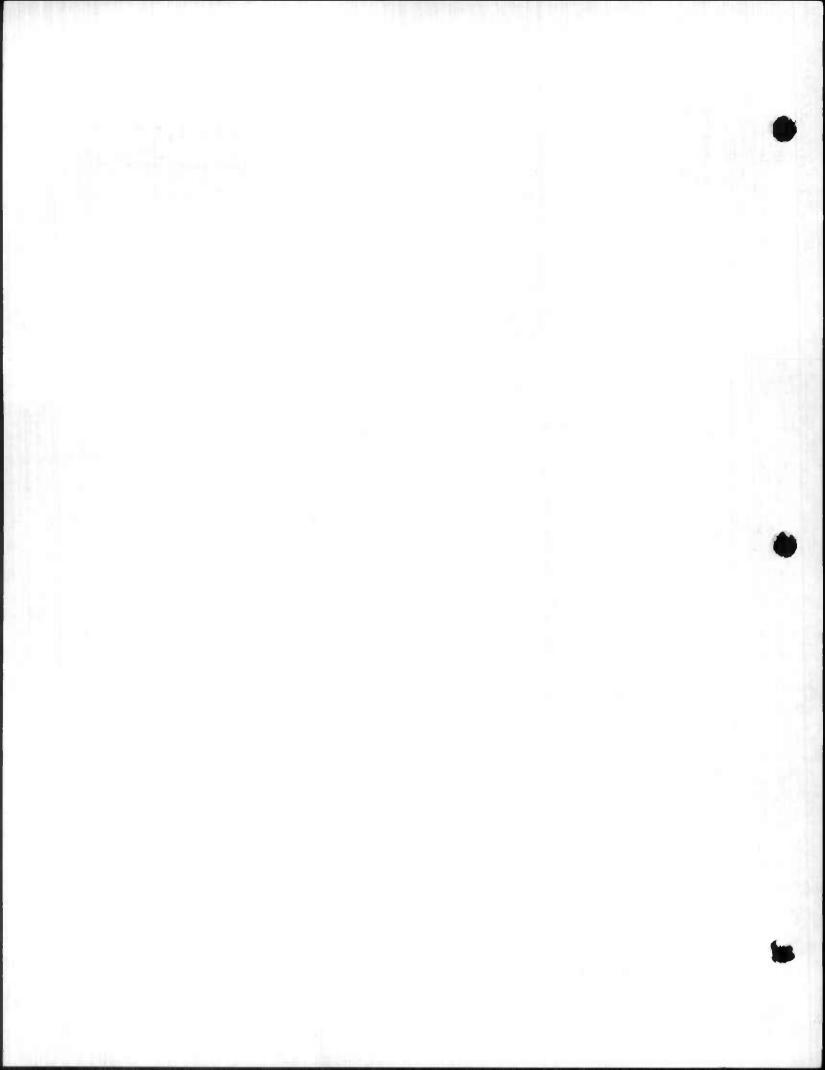
32. Registrer's Signeture

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

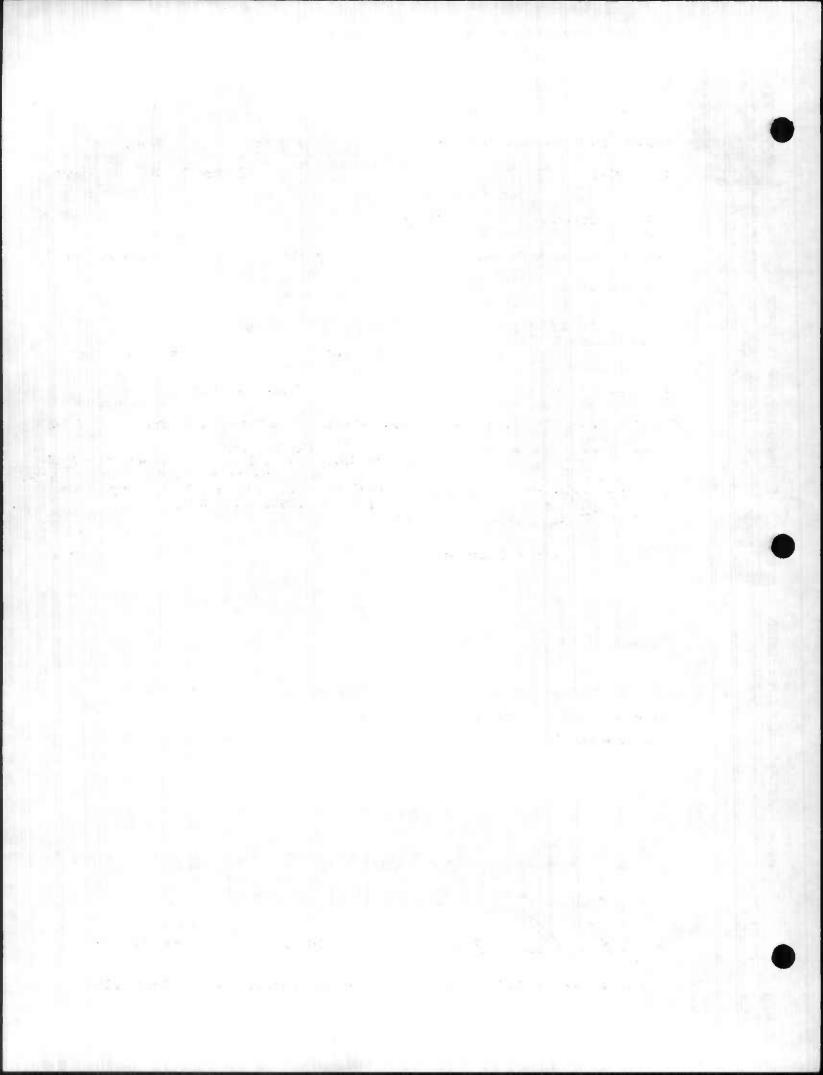


			Cenilica	te or	Deam			1	
Physician /Medica	JAY A		CLODFELTE		V	May 13,	Day Ye	nar lan	
Examine	4a Facility Name (If not institution, give st	reet and number)		1					
3/		7 Ane (In we le	et hirthday) If Unde	er 1 Year	If Under 24 Hrs.	8. Date of Birth	Montgo		r Foreic
Funeral Director	577-20-0870 XX	M 2□F 73	Yrs. Months	Days	Hours Min.	July 24,	1925 N	Country)	
Pu Man	10a. State 10b. County	10c. City,	Town or Location						
ith the Marylar or 28a-f show a notified at	Maryland Montgomer	y P	otomac					1 Yas	2)(1)
7 28 2 28	10e. Street and Number		10f. Z			10		it Country?	
15 will	8401 Post Oak Road	d							
ind 21215-0020 be filed within 72 hours after death with the Maryland tal Hygiane. I define than "natural", or frame 23a or 28e-f show event, the Model Examiner must be notified at	11. Marital Status 12 1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No			lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	Black,	White, etc.	
0002 ours	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:							
Maryland 21215-0020 at 2 should be filled within 72 hours at the and Mentel thyglene. 77 is marked other than "natural", or traumatic avent, the World I arm.	15. Decedent's Educi (Specify only highest grade	ation completed)	16a. Decedent's Us (Give kind of w	ual Occup rork done use retire	ation during most of wor d)	king	16b, Kind of Busin	ness/Industry	
within than	Elementary/Secondary (0-12)	College (1-4or 5+)					)epartmen	nt of Arm	у
d Hyging d had a h	17. Father's Name (First, Middle, Last)		Budgetin			ne (First, Middle, N	faiden Sumame)		
ylan buld be Mental arked a	Jay Alexander C	Potomac   10   20   20   20   20   20   20   20							
shou and M									
Malth 2		Secretary Name (if not institution, give street and number)   46. Cby, Town or Location of Death   Montgomery							
O'He Than	A CLODFELTER May 13 Day 1998 11:15 AM 2 Facility Name (if not institution) give street and runnber)  40. CBy, Town, or Location of Datesh 40. CBy, Town, or Location of Datesh 40. Carby, Town, or Location of Datesh 40. Days of Bash 40. CBy, Town, or Location of Datesh 40. Days of Bash 40. CBy, Town, or Location of Datesh 40. Days of Bash 40. Day								
Pag nent ant: if	4 Donayor 5 Other (Specify)	JAY A CLOPFELTER May 13, 0 po 1999 11:15 AM  I Facility Name (if not instablic, give arread and number)  Suburban (Hospital)  Social Security Number  I Social Security Number  I C. Sex  7.7 Ape (in yex, fact berdely)  100. Control  101. Control  102. Control  103. Stelle   100. Country  104. CPF, Town or Location  I C. Sex  107. 20870  I C. GPF, Town or Location  I C. Sex  108. Stelle   100. Country  Ruffled Stelle,   100. Country  Ruffled St							
Baltimore, Maryland 21215 permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "ne any injury or other traumatic event, the Heal	1. Decoded in Name (First, Medific, Last)  A CLODFELTER  CLODFELTE								
mew									
Physician /Medical	Immediate Cause (Final disease or condition			•				Onset and t	Death
Examiner								t	
D ==	b.				INJUR	7		i i	
secut and al-tran	Sequentially list conditions, if any, leeding to immediate	200	32 H						
68760, ilificate be executed g physician and as the burial-transit	cause. Enter Underlying Cause (Disease or injury c.								_
<b>∞</b> ₹ ₹ ₹	resulting in death) Last				11/4/6	ARCTINA	.1	i	
Box 6	d.	ACUTE	MYOCAR	(1)//	16 1101	MICHO	0	!	
P.O. Box 6 that the death certification of ed by the extending of deteched for use as	Part II. Other significant conditions cont	ributing to death but not resul	ting in the underlying	cause gi	ven in Part I.	23b. Did to	obacco use contr	ibute to the cause	of de
P.C of the of the	LUNG CANO	ER				1 🗆 Y	es 2 No 3	Probably 4	Unk
S to be				-		24a. Was a		available prior	to
The law require cata has been si							-chir	of death?	
al Re le cete he cete he								1 Tes 2L	1 140
f Vital Prysician: The securiticata director, pag	25. Was case referred to medical axaminer?	ospital:	:D/O	Ot Ot				(Specify)	
Vision of Vita	27. Mannes of Death		28b. Time of						
On ding	1 Natural 5 Pending investigation	(Month, Day Year)							
S Para	3 Suicide 6 Could not be determined	28e. Place of Injury - At hos building, etc. (Specify,	ne, farm, street, tact	ory, office		28f. Location (S City or Town	treet and Number n, State)	or Rural Route Nun	n <i>ber</i> ,
To the Hospital of Within 24 hours a To the Funeral Dompletely filled	27. Manner of Death 1	cian: To the best of my know er: On the basis of examinati and manner stated.	rledge, death occurre on and/or investigation	ed at the toon, in my	ime, date and plac opinion, death occ	e, and due to the curred at the time, of	ause(s) and mani late and place, ar	ner as stated. Indicate to the cause(	(s)
To the Hos within 24 hd To the Fun completely	29b. Signature and title of certifier	and manner distress	2	29c. Licen	se number	1	29d. Date signed	(Month, Day, Year)	
F 3 F 8	1	PHYSICIAN D23/77 05/14/99.  and address of person who completed cause of death (Item 23a) (Type, Print).							
78.	30. Neme and address of person who cou	Neme and address of person who completed cause of death (Item 23a) (Type, Print)							
	MARIO O. BELLEDONNE, MD , / 121 CONGRESSIONAL IN 205 ROCKVILLE								
	31. Date filed (Month, Day, Year)	32. Registrar's Signat							



State of Maryland / Department of Health and Mental Hygiene Q Q 171, [6]

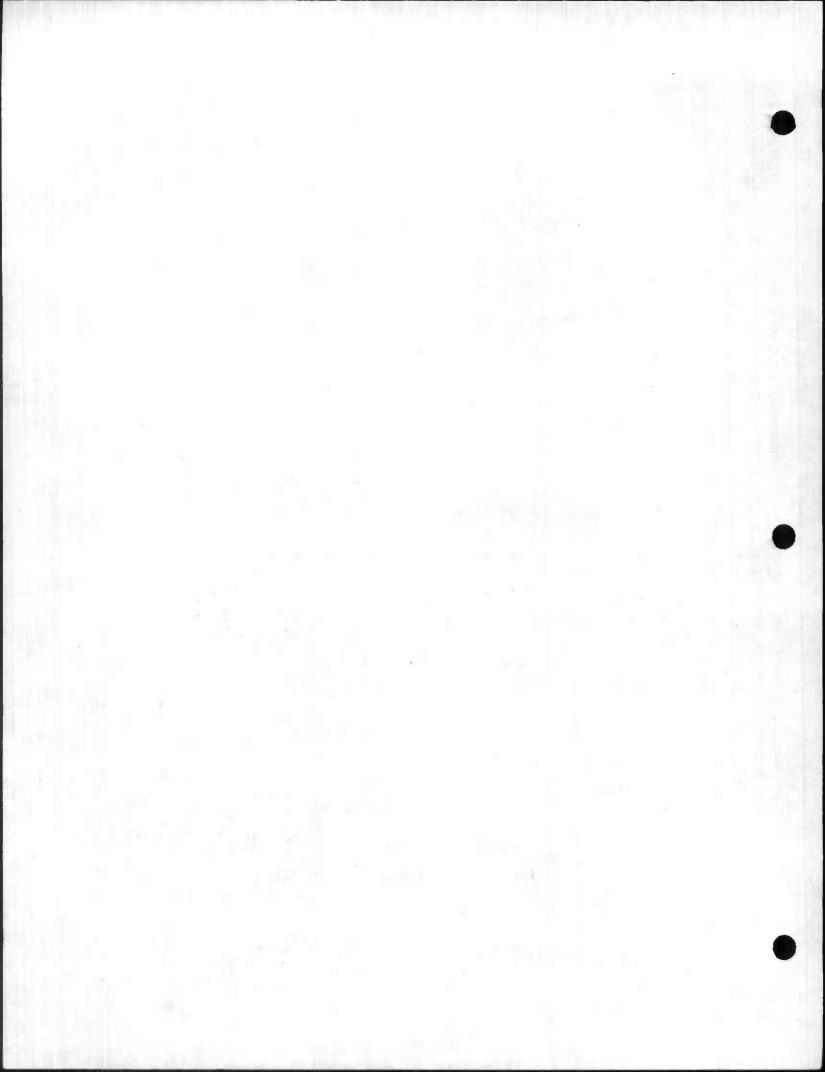
				Certifica	ate of	Death		Reg. No.	) !	1440
	1. Decedent's Name (First, Middle,	Last)					2. Date of De	eth		3. Time of Death
Physician	Kathryn H	Conc.	а				Month	Day 15, 19	Year	2:35 PM
/Medical Examiner	4a Facility Name (If not institution,					4b. City, Town, or			y of Death	
Examiner	Randolph Hill		Ното			Wheator		Mon	tgome	***
-			e (In yrs. las	t birthday) If Und	ter 1 Year					
Funeral Director	443-01-8373 Usual Residence of Decedent	1□M 2፟ØF	81	Yrs. Month	s Days	Hours Min.	October	17, 1917	Ok	place (State or Foreign ntry) Lahoma
No to	10a. State 10b. County		10c. City, T	Town or Location						10d. Inside City Limits
form 23a or 28a-f show free must be notified at funeral Director	Maryland Montgo	merv	011	nev						1 ☐ Yes 2 ☑ No
or 28s-f s be notified Director	10e. Street and Number				Zip Code			10g. Citizen of	What Cou	ntry?
	18404 Paradise C	ON Torreco				20832		II-n-i +	ed St	
era	11. Maritat Status	12. Was Decedent		13. Was Dec			Specify Yes or No		ce - Ameri	
by	1 Never Married 2 Married 3 Widowed 4 Divorcad	Armed Forces?				Hispanic Origin? (Sen, Mexican, Puer Specify:	to Rican, etc.)	Spec	ack, White,	ite
8	15. Decedenl's	Education	1	16a. Decedent's U:	suai Occup	pation	4.5	16b. Kind of	Bustness/in	ndustry
Completed	(Specify only highest ( Elementery/Secondary (0-12)	grade completed)  College (1-4or 5	5+)	life. DO NOT	use retire	during most of wo	rking			
E o	12	Solida (1-401)	,	Sec	retai	У		DC Go	vernm	ent
Be C	17. Father's Name (First, Middle, La	st)				18. Mother's Na	me (First, Middle	, Meiden Sume	me)	
0	James H. Kimbro					Hester	L. Nel	ıms		
F	19e. Informent's Name/Relationship			19b. Mailing Addre	ss (Stree	and Number or R			n, Stete, Zi	p Code)
	Patricia A. West									Land 20832
	20a. Method of Disposition	Lexii/ Daugii	20b. Ptac	e of Disposition (A etery, cremetory o	leme of	e cove I	Date Date	20c. Location		
once.	1 ☐ Burial 2 ☑ Cremation 3		cem	etery, cremetory o	r other pla	May 17,	1999		1	
	4 Donation 5 Other (Spe		Mon			torium,				aryland
OUCE.	21. Signature of Fylheral Service tid			D .1.		Inc., 3				neral Home
3	VIT AT		MO1126			Marylan			mery	Avenue,
	23a. Pert 1. Enter the disease, or co shock, or heart failure. List on	mplications that caused	the death.	Do not enter the m	ode of dy	ng, such as cardia	c or respiratory a	rrest,	t	Approximete Interval Between
an	SHOOK, OF HOUR TAILUTO. LIST OF	ly one cause on each in	110.						1	Onset and Death
al	Immediate Cause (Final	Pneur	nonia							1 month
er	disease or condition resulting in deeth)	a		s a consequence of	40.			-	1	1 monen
ē			Due 10 (01 e.	s a consequence c	м).				1	
Examiner	Conventelly Victorial	b	Due to for a	s a consequenca o	d).					
Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury		Due to (or a:	o a consequence o						
<u>'a</u>	Ceuse (Disease or Injury that initiated events	c	Due to /ex -	a connectioner	4)-					
edicai	resulting in deeth) Lest		Due to (or 85	s a consequenca o	1/.				1	
-		d								
Ta L										
Physician/N	Pert II. Other significant conditions	contributing to death b	ut not resultin	ng in the underlying	g cause gi	ven in Part I.	23b. Did	tobacco uss c		to the cause of death
	Cerebrovascula	r Accident					1 🗆	Yss 2XNo	3 ☐ Pro	obably 4 Unknow
by									1	
Completed	Severe Dementi	а						en eutopsy ormed?	a	Vere autopsy findings vallable prior to
ple										ompletion of cause f death?
E							10	Yes 2X No	1	□Yes 2□No
BeC	25. Wes case referred to medical					26. Place of De	ath (Check only	one)		
0	exeminer? 1 Yes 2 No	Hospital:	ent 2 FE	VOutpatient 3	DOA Ot	her:	Home 5 ☐ Res		ther (Spec	itv)
-	27. Manner of Death	28a. Date of Inju (Month, De		3b. Time of	28c. Inju			how injury occ		-71
tor	1 XNaturel 5 Pending Investigat		y Year)	Injury M		rk? ]Yes 2□No				
Certification:	3 Suicide 6 Could no	be gen Diese of les	ury - At home	e, farm, street, fact			28f. Location	(Street and Nur	nber or Rui	ral Route Number,
Ī	4 ☐ Homicide determine	building, et	c. (Specify)	-,,	,			wn, State)		
edical Ce	(Check only 2 Madical Ex	Physician: To the best aminar: On the bests of	of my knowle	edge, death occurrent and/or investigation	ed at the ti	ime, dete end plac opinion, death occ	a, and due to the urred at the time	cause(s) and i	manner as	stated. to the cause(s)
Medical Certi	one)	and manner st	17		nno Licon	eo aumbor		20d Data sign	and (Month	Day Veer
~	29b. Signeture end titte cartifier	// //	/			se number		29d. Date sign		
	XXXIX	Oxylo	21			D09834		May 1	/, 19	999
	30. Name and eddress of person with	o completed cause of d	leath (Item 2	3a) (Type, Print)						
	Barry N. Rosenba				Aveni	ie, Kensi	noton 1	Marvlan	1 20	895
CARA	31. Dete filed (Month, Day, Year)		ar's Signetur		A	Le Kellel		y Luii		
State	MAV 1 0 1		man	4	lan.	11				



State of Maryland / Department of Health and Mental Hygiene 99

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ician					OGIL	mouto or	Death		Reg. No.			
ician	1. Decedent's Name (First, A	Viddle, Last	1)					2. Dete of De	ath	Vasa	3. Time of Deet	
	Elizabeth A	. Cro	we					Month MAY	Dey 19	Year	4:45 Pm	
dical niner	4a Facility Name (If not instit			ber)			4b. City, Town	n, or Location of Deet	4c. Count	y of Death		
,,,,,,,	Holy Cross	Hooni	+01				Silver	Carina	Mon	tgome	F37	
	5. Social Security Number	6. Se		Age (In yrs. le	ast birthday)	If Under 1 Yea	r   If Under 24	Hrs. 8 Dete of Bir	th			
al or	116 01 2671	10	M 2ØF		Yrs.	Months Days	Hours	Min. (Month, Da	y, Year)		lace (State or Fore	
"	116-01-2671 Usual Residence of Deceden	ot		93				Aprii	16,1906	Eng.	Land	
	10a. State 10b. Co	-		10c. City	Town or Loca	ation				1	Od. Inside City Lin	
5					lockvil				1 ☐ Yas 25			
2	Maryland Mon		10g. Citizen of What Country?									
Director	10e. Street and Number					10f. Zip Code			10g. Citizen of	What Coun	try?	
	5128 Clavel T	errac	e			2085	3		USA			
Funeral	11. Merital Status		12. Wes Decede	ent Ever in U,S	S. 13. W	es Decedent of	Hispanic Origin	n? (Specify Yes or No Puerto Rican, etc.)		ce - Americ		
	1 Never Married 2	Merried	1 Yes 2	⊠ No				r bento rnoan, etc.)		ick, White,	etc.	
	3 ☑ Widowed 4 ☐ Divo	orced	If Yes, Give Yeer or Dete		11	☐ Yes 21 No	Specify:		Speci		hite	
	15. Decr	edent's Edu	cation		16a. Decede	ent's Usuel Occi	pation		16b. Kind of B			
į	(Specify only hi	ighest grad	le completed)		(Give ki	ind of work done  O NOT use retir	e during most o	of working				
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	12	della face)			Homem	aker	40.44-4-4	- 01 (Fi 0.6)-d-11-	Own !			
D	17. Father's Name (First, Mid	ddie, Last)					18. Mothers	s Name (First, Middle	Meiden Sumai	me)		
2	Thomas 0'	Brien					Phoe	ebe Dave	nport			
	19e. Informent's Neme/Relat	tionship (Ty	rpe, Print)		19b. Meiling	Address (Street	et and Number	or Rural Route Numb	er, City or Town	, State, Zip	Code)	
	Brian G. Cro	TATE	(9)	on)	5128 C	lavel T	errace	Rockvill.	e.Marvl	and	20853	
ŀ	20a. Method of Disposition	WC	(3,	20h. Pk	ace of Disposi	ition (Neme of		Dete	20c. Location			
	1 ☑ Burial 2 ☐ Cremet	tion 3 🖾 R	Removel from St	ete ce	metery, creme	etory or other pl	BC8)					
	4 Donetion 5 Othe	er (Specify)		St.		nd Ceme		5/20/99			ork	
	21. Signeture of Funeral Sen	vice Licens	90		22. Fr. 2	Name end Add	Collin	s Funeral	Homo	Tno		
	> Sture.	11/	ti- 1					lvd.,W.,Si			MD 2090	
	23a. Pert1. Enter the disease	e or compl	lications that can	seed the death						ring,	Approximata	
Examiner		•	. fau		as a conseque			grad 1	/ pr (	)mc	ň	
	Sequentially list conditions		Confe	ISION		1	1 -1	NV	1			
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					)	LUD	100				
Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1	C= 1=	Due to (or	as e conseque	•	1/14	Dia				
	Cause (Disease or injury that initiated events resulting in death) Last		Seven	Due to (or	SRONG	HITIS	1/2	Die				
	that initiated events		Seven	Due to (or	SRONG	HITIS	iven in Pag I.	23b. Dld	tobacco use co	ontribute to	the cause of dea	
	Cause (Disease or injury that initiated events resulting in death) Last		Seven	Due to (or	SRONG	HITIS	iven in Part.	23b. Did	N/	ontribute to		
	Cause (Disease or injury that initiated events resulting in death) Last		Seven	Due to (or	SRONG	HITIS	iven in Phr 1.	1000	1			
	Cause (Disease or injury that initiated events resulting in death) Last		Seven	Due to (or	SRONG	HITIS	iven in Plat I.	1 □	Yes 2 No	3 Prot	bably 4 Unkn	
	Cause (Disease or injury that initiated events resulting in death) Last		Seven	Due to (or	SRONG	HITIS	iven in Part.	1 □	Yes 2 No	3 Prot	pably 4 Unknown under the unitable prior to mpletion of cause	
	Cause (Disease or injury that initiated events resulting in death) Last		Seven	Due to (or	SRONG	HITIS	iven in Part.	1 □	Yes 2 No an autopsy primed?	3 Prot	ere autopsy finding allable prior to inpletion of cause death?	
Completed by Physician/	Cause (Disease or injury that initiated events resulting in death) Last  Pert ti. Other significant con	nditions con	Seven	Due to (or	SRONG	HITIS	iven in Part 1.	1 □	Yes 2 No an autopsy ormed?	3 Prot	pably 4 Unknown under the unitable prior to mpletion of cause	
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State of Maryland / Department of Health and Mental Hygiene

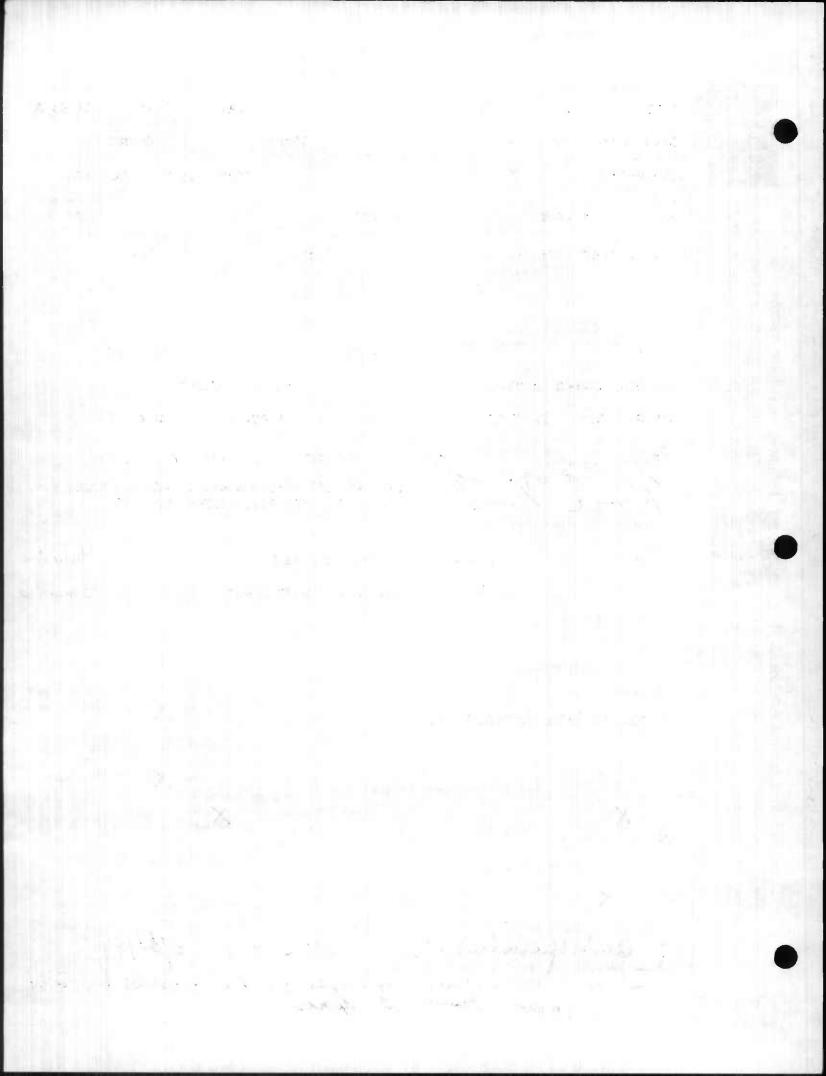
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AND THE RESERVE OF THE PERSON

State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death **Physician** 18 1999 F. CARROLL MAY 11:05 AM /Medical 4a Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5498 LANDING NECK ROAD TRAPPE TALBOT If Under 1 Year If Undar 24 Hrs. 5. Sociel Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Months Deys Hours 1□ M 2□ F Yrs. 68 220-26-2091 Director SEPT.1-1930 MARYLAND Usual Residence of Decedent the Meryland 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Modical Examiner must be notified at TALBOT EASTON 1 No Yes 2 No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 991 N. WASHINGTON ST. 21601 USA death Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian. permit. Peges 1 and 2 should be filed within 72 hours after to Department of Health and Mentel Hygiene.
Important: if Itam 27 is marked other than "natural", or itam any injury or other traument. Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0020 If Yas, Give Yeer or Detes: 1 Yes 2 No Specify: WHITE Specify: by 3 Widowad 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) -0-Elementary/Secondary (0-12) HOUSEWIFE OWN HOME 18. Mother's Nama (First, Middle, Malden Sumame) 17. Fether's Neme (First, Middle, Last) RAYMOND LINWOOD MARSHALL ETHEL IRELAND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) AMY G. CARROLL/ DAUGHTER 5498 LANDING NECK ROAD, TRAPPE, MD 21673 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, Stete WBurial 2 ☐ Cremetion 3 ☐ Removal from State SPRING HILL CEMETERY 5-21-99 EASTON, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Sarvice Licanses 22. Neme end Address of Fecility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final turinitas Mater. diseasa or condition resulting in death) Examiner Examiner Sarcoma wenne physician and the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of) Box 68760, certificate be Physician/Medical Due to (or as e consequence of): 98 ed by the attending detached for use as P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? signed by d 3 Probably 4 ☐ Unknown 2 No Division of Vital Records. Aq 24b. Were autopsy findings aveilable prior to complation of causa of death? 24e. Wes an autopsy Completed peed 1 Yes 1 ☐ Yes 2 ☐ No certificate funeral director, 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only ona) 1 ☐ Yes 2 No 27. Manner of Death Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28d. Dascribe how Injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: After 5 Pending Naturel 1 Naturel 2 ☐ Accident 1 ☐ Yes 2 ☐ No death. investigation or Attend after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide n 24 hou. Hospital 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hos To the Fune completely fi Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. Licanse number 29b. Signature and title of certifier 30. Ner impleted cause of deeth (Item 23e) (Type, Print) OM WOTE AS SA CUI SUA MASTA NOALA JOHN 31. Date filed (Month, Day, Year)

State Registrar



12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) end manner as steted.

2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) end menner stated.

29c. License number

29d. Date signed (Month, Day, Year)

6

Division of Vital Records, Hospital

> State Registrar

edical

29e. Certifier

(Check only one)

29b. Signeture and title of cartified

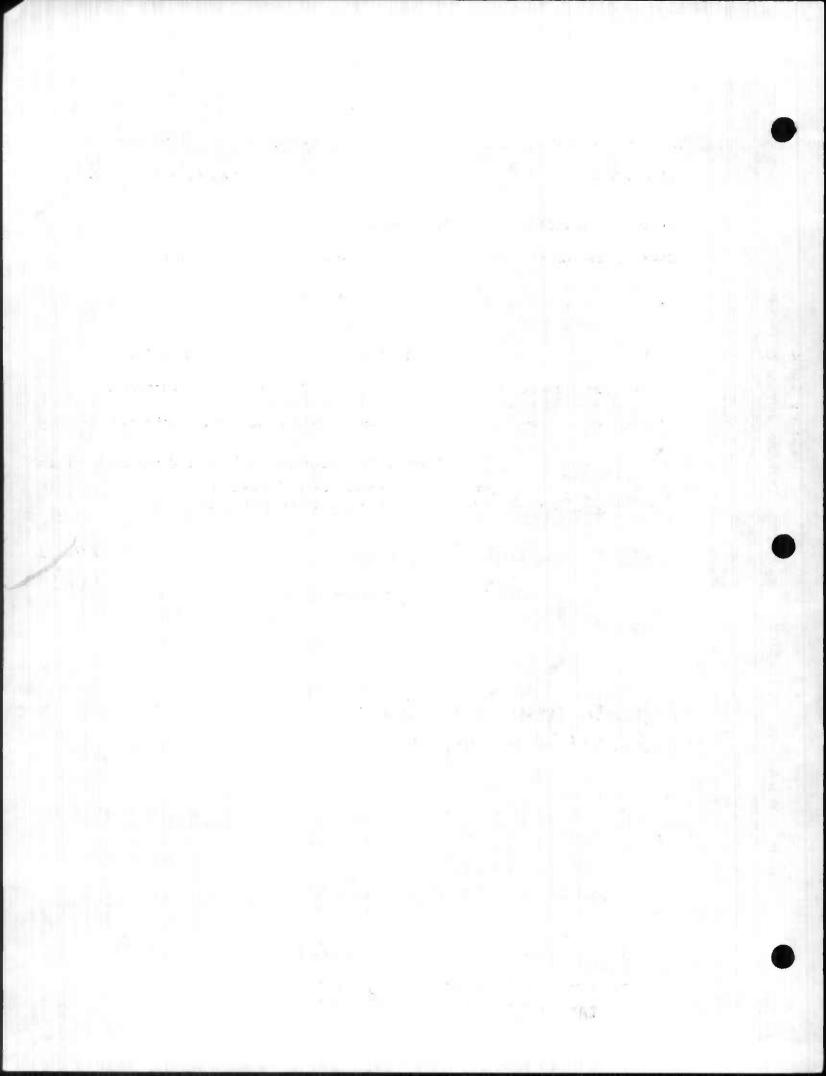
ann

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

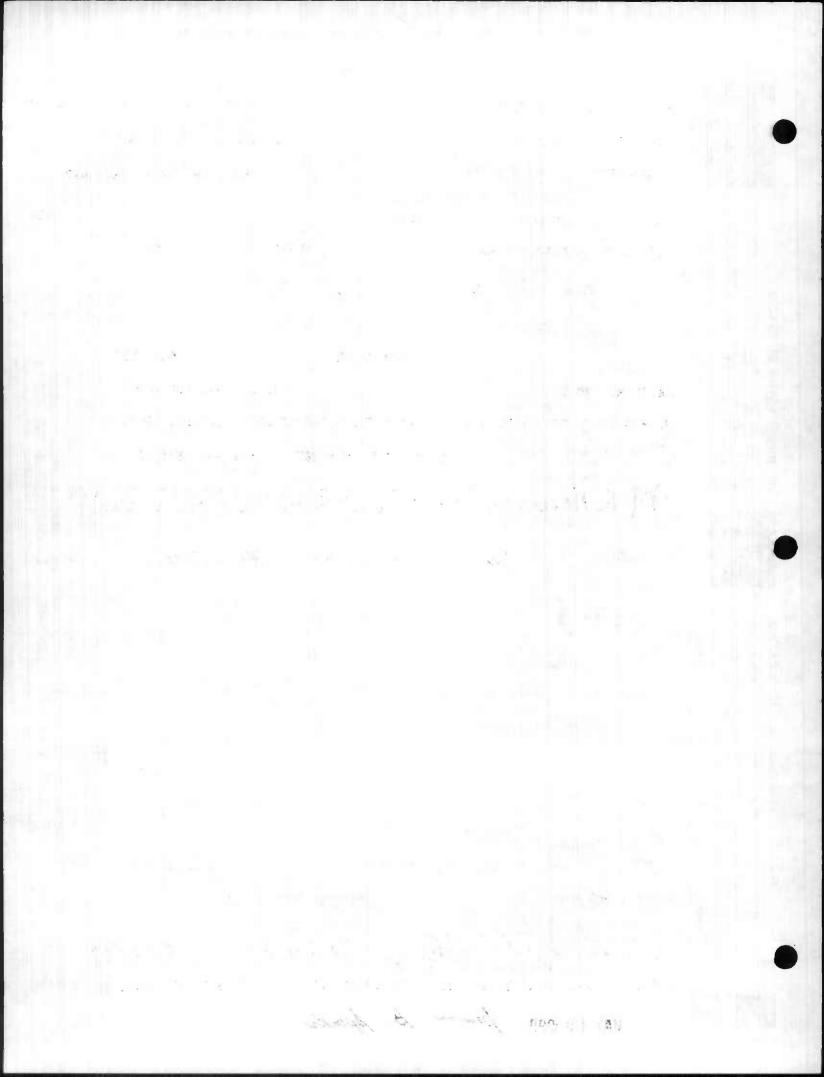
David Smith M.D., 501 Idlewild Ave., Easton, Maryland 21601

1999 A Signatures

within 2



	Certificate of De	7.03: 110:	15 -1
Physicia	Decedent's Nama (First, Middle, Last)     RUTH B COLEMAN	2. Data of Death Month Day 1999 3. Time of 2:4	O PM
/Medica Examine		City, Town, or Location of Deeth 4c. County of Death	
LAdimire	27815 ST. MICHAELS ROAD	EASTON TALBOT	
Funeral Director		Hours Min. Solution of Birth (Month, Day, Year)  NOV. 19, 1919  9. Birthplace (State of Country)  MARYLAND	or Foreign
hend #	10a. Steta 10b. County 10c. City, Town or Location	10d. Insida C	ity Limits
a-f ah	MD TALBOT EASTON	1 □ Yas	2/OXNo
th with the Ma 23s or 28s-fa	10e. Street and Number 27815 ST. MICHAELS ROAD 20101. Zip Coda 2	21601 USA	
ire, Maryland Z.I.Z.I.D-UUZU s.1 and 2 should be filed within 72 hours after deeth with the Maryland l. Health and Mental Hygiena. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Medical Examinal must be notified at	If Yas, Giva 1 ☐ Yas 2 W No S Yaar or Detes:	anic Origin? (Specify Yes or No- Mexican, Puerto Rican, atc.)  14. Race - Amarican Indien, Bieck, White, atc.  Specify: WHITE	
ed within 72 hours at ygiena. Per than "natural", or it, the Mooical Exam.	15. Decedant's Education (Specify only highest grade completed)  Elamantary/Secondary (0-12)  12  18a. Decedent's Usuel Occupation (Give kind of work done during tife. DO NOT use ratived)  HOMEMAKER	on 16b. Kind of Businass/Industry OWN HOME	
tal Hygin	17. Falhar's Nama (First, Middle, Last)	3. Mothar's Nama (First, Middla, Maidan Sumame)	
should be nd Mentai marked o	HARRY R. BROLL	RUTH AUGUSTA LOCKHART	
Mal ylallo d 2 should be file th and Mental Hy 77 is merked oth traumatic event		d Number or Rural Route Number, City or Town, State, Zip Code) AELS ROAD, EASTON, MD 21601	
mit. Pages 1 and 5 partment of Health portant: If Item 27 is yinjury or other tr.	20a. Mathod of Disposition 20b. Place of Disposition (Nama of	Data 20c. Location - City or Town, Stata	
	1 Surial 2 Crametion 3 Ramovel from Stata 4 Donation 5 Other (Specify)  1 SPRING HILL CEMETER	S-12-99 EASTON, MD	
permit. Pages Department of important: If any injury or page.	21. Si nature of Funeral Servita Licensee  22. Nama and Addrass of FELLOWS, HEI	LFENBEIN & NEWNAM FUNERAL HOME,	P.A.
Physician	23a. Part I. Eltar tha disaase, or complications that caused the daath. Do not entar the mode of dying, s shock, or haart failura. List only one cause on each line.	ISON ST., EASTON, MD 21601 such as cardiac or raspiratory arrast, Approxime interval Ber Onsat and	ota otween Death
. /Medical Examiner	Dua to (or as a consequence of):	al DeubiTus 3da	در
ned	b		- 3
an and	Sequantially list conditions, if any, leading to immediate causa. Entar Undarrying Causa (Disaasa or injury		
g physician and as the buriel-transit	Causa (Disaasa or injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of):		
death certified attending of for use a	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	in Part I. 23b. Did tobacco usa contributa to the cause	of death?
signed by the attending d be detached for use a		1 Yes 2 No 3 Probably 4	] Unknowr
peed should		24a. Wes en eutopsy performed?  24b. Ware autopsy aveilable prior completion of of death?	to
The is		1 Yas 2 No 1 Yes 2	No
ician: T	25. Was casa rafarrad to medical axaminar?	6. Placa of Daath (Check only one)	
Physician: this cartific	Tampatan 22 divolpation of ook	4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) t 28d. Dascribe how injury occurred	
Attending ar death.	27. Manner of Death 1 ☑ Natural 5 ☐ Panding 2 ☐ Accidant invastigation  28a. Data of Injury (Month, Day Year) 28b. Tima of Injury Work? 1 ☐ Yas	s 2 No	
5 4 5 5	3 ☐ Suicida 4 ☐ Homicida 6 ☐ Could not be datarmined 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)	28f. Location (Street and Number or Rural Route Nur City or Town, State)	m <i>ber</i> ,
To the Hospital within 24 hours : To the Funeral completely filled	29a. Cartifiar (Check only one)  1 Cartifying Physician: To tha best of my knowledga, daath occurred at tha tima, (Check only one)  1 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion and mannar statad.		(s)
ro the within To the comple		umber 29d. Data signed (Month, Dey, Year)	
->-0	July (16 hotor D 3	1466 5/10/99	
	30. Name and address of person what completed cause of death (Itam 23a) (Type, Print)		
	LUDWIG J. EGLSEDER, III, M.D., 505A DUTCHMAN'S	S LANE, EASTON, MD 21601	
State Registra	31. Data filed (Month, Day, Year)  32. Registrar's Signatura		



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 1999 **Physician** Osam Frank Oscar Davidson M ay /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Nema (If not institution, giva street and number) Examiner 20029 Leitersburg Pike Washington County Hagerstown If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthpleca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) **Funeral** Months 15℃M 2□ F Days 81 009-07-4678 Director March 27,1918 Vermont Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Insida City Limits 10a State 10b. County r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Maryland Washington Co. Hagerstown 1 ☐ Yes 2X No Director 10g. Citizen of What Country? 10e. Street and Numbar 10f. Zip Code 20029 Leitersburg Pike 21742 USA Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Armed Portons

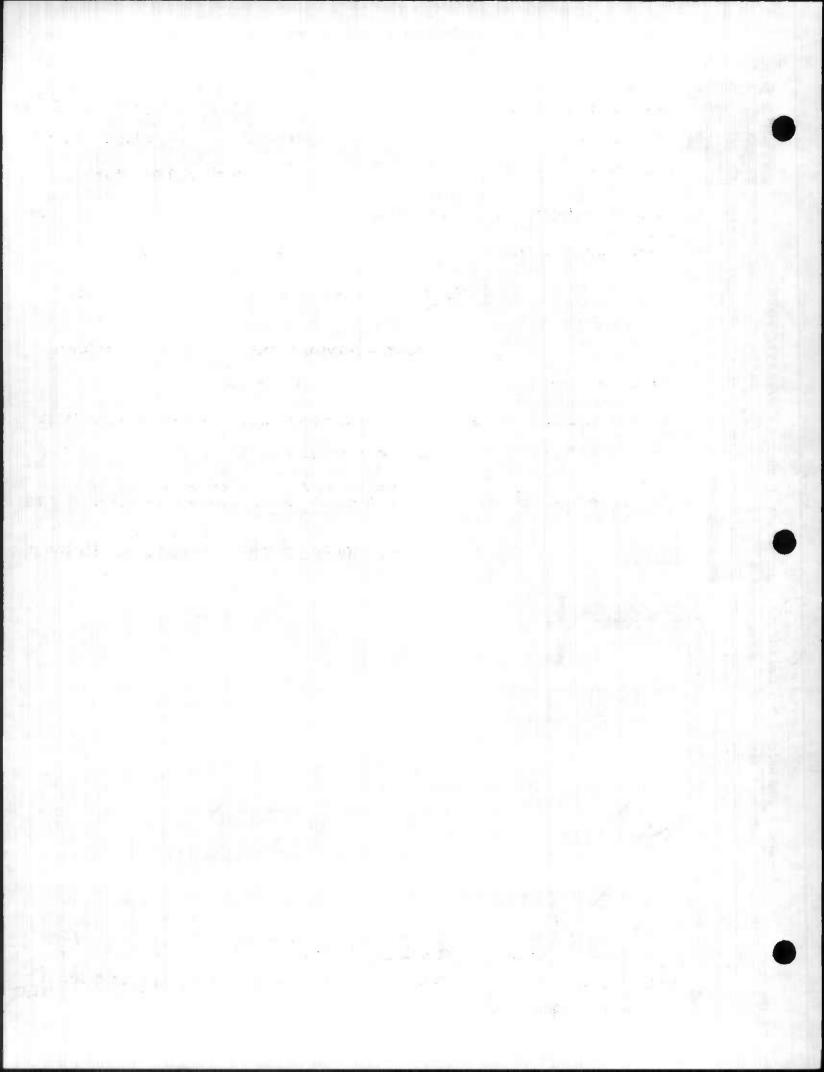
1 Syes 2 So / 27/43

If Yes, Give Year or Dates: 4/3/46 filed within 72 hours after 1 ☐ Never Married 2 ☑ Married White Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: à 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. other than College (1-4or 5+) Elementary/Secondary (0-12) Sales & Service Person Business Equipment 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fathar's Name (First, Middle, Last) 1 and 2 should be fill Health and Mental H tem 27 is marked off Leslie Davidson Elsie Hurst 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) 19a, Informant's Name/Relationship (Type, Print) parmit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra Kathleen L. Davidson/Wife 20029 Leitersburg Pike, Hagerstown, Maryland 21742 Baltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20a. Method of Disposition 20c. Location - Cify or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn MEmorial Park May 15 Hagerstown Maryland 21. Signatuse of Funeral Service Licensee 22. Name end Addrass of Facility Douglas A. Fiery Funeral Home ter the disease for complications that caused the death. Do not enter heart failure. List only one cause on each line. 1331 Eastern Blvd., N., Hagerstown, Maryland 21742

ariter the mode of dying, such as cardiac or respiratory errest.

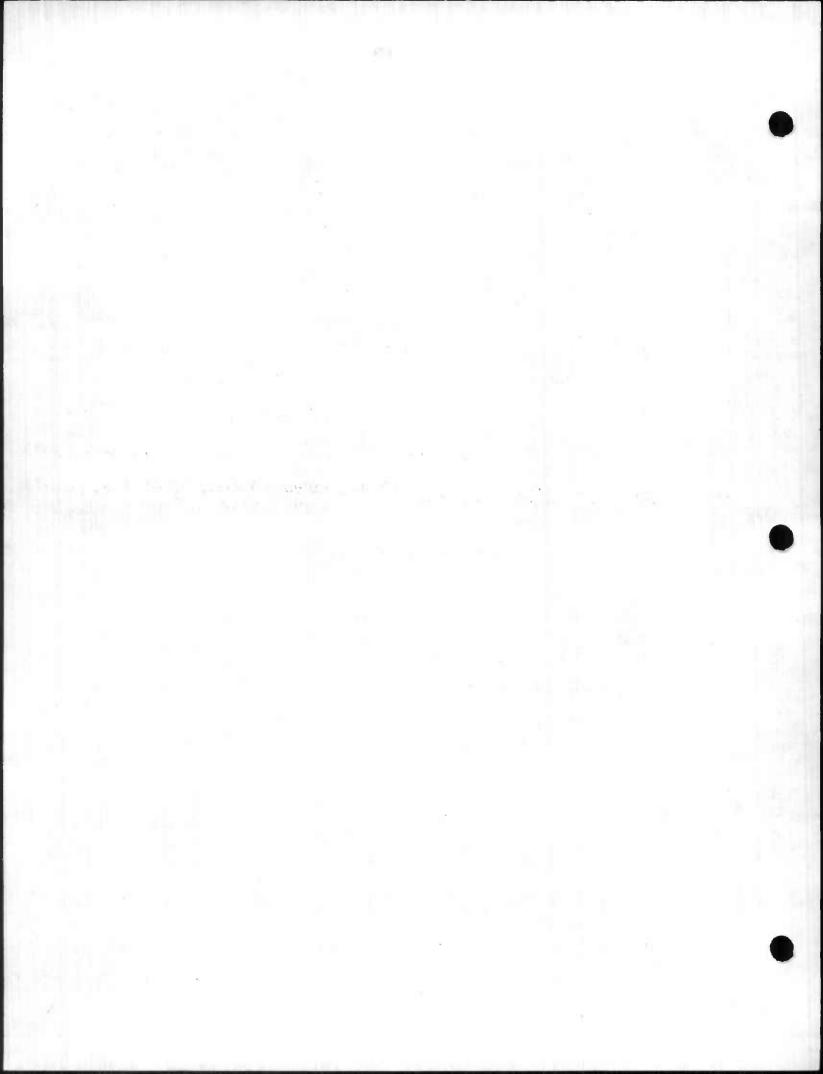
Approximate Intervel Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examir Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 8 Due to (or as a consequence of): 2 957 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 4 Division of Vital Records, 2 24b. Were autopsy findings available prior to completion of cause of death? Completed 24s. Was an autopsy page 2: 1□ Yes 2□ No 1 □ Yes 2 □ No certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 25 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 (Cother (Specify) # 27 Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending after death. Director: Alt 1 Yes 2 No investigation 2 C Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29e. Certifier completely (Check only one) within 2 To the the th 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ND o completed cause of death (Item 23e) (Type, Print) Neme and address of person 2 Hamdan 36 HIND 32. Registrer's Signature Date filed (Month, Day, Year) State MAY 1 4 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene

_	_	Decedent's Name (First, Middla, Las.	State of Mai		Certificate o			Reg. No.	. /	3. Time of Death
Physi	cian		, DICKERSON	7			Month	Day 19.	Year 1999	3:10AM
/Med		4e Facility Nama (If not institution, giva		V		4b. City, Town, or	May Location of Death			3: IUAM
Exam	iner	CIVISTA MEDICA				La Plat		10.00	rles	
Funera Directo				In yrs. last birtho	Months Day	ar If Under 24 Hrs		h	G Distributor	e (Stata or Foreign irginia
anyland show	70	10a. Stata 10b. County		Oc. City, Town o						Inside City Limits
The M	ecto	MD Charle 10e. Street and Number	S	Nanje	2MO y 10f. Zip Code			10g. Citizen of V		
23a or	Funeral Director	5130 Port Toba	cco Road		206	62		USA		
Baltimore, Maryland 21215-0020 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumstic event, the Medical Emotives must be notified at	by	11. Marital Status  1 Nevar Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 No If Yas, Giva Year or Dates:	ar in U,S.	13. Was Decedent of If Yas, specify Control of Image 2 ☐ Yas	f Hispanic Origin? (Suban, Maxican, Puer Specify:	Specify Yas or No to Rican, etc.)	Specify	ck, White, etc. White	
1215-0 ithin 72 ha	Completed	15. Decedent's Edu (Specify only highast grad Elementary/Secondary (0-12)	cation (a completed) College (1-4or 5+)	((		na during most of wo red)	rking	16b. Kind of Br		try
d 212 filed with Hygiene. ther the	S	12		St	ore Own			Retai		
yland build be fil Mental H arked out	To Be	17. Father's Nama (First, Middla, Last) Elmo Earl Dick	erson				me (First, Middle, Margar			
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Baltimore, Maryland 21215-0020 pemit. Pages I and 2 should be filed within 72 hours at Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or any Inlury or other traumatic event, the Medical Enton		20a. Mathod of Disposition 1 ☐ Burial 2 ② Cremation 3 ☐ 6 4 ☐ Donation 5 ☐ Other (Specify)	Ramoval from Stata	camatary,	isposition (Neme of cramatory or other politan C	rematory	Data 75/22/9	20c. Location -		
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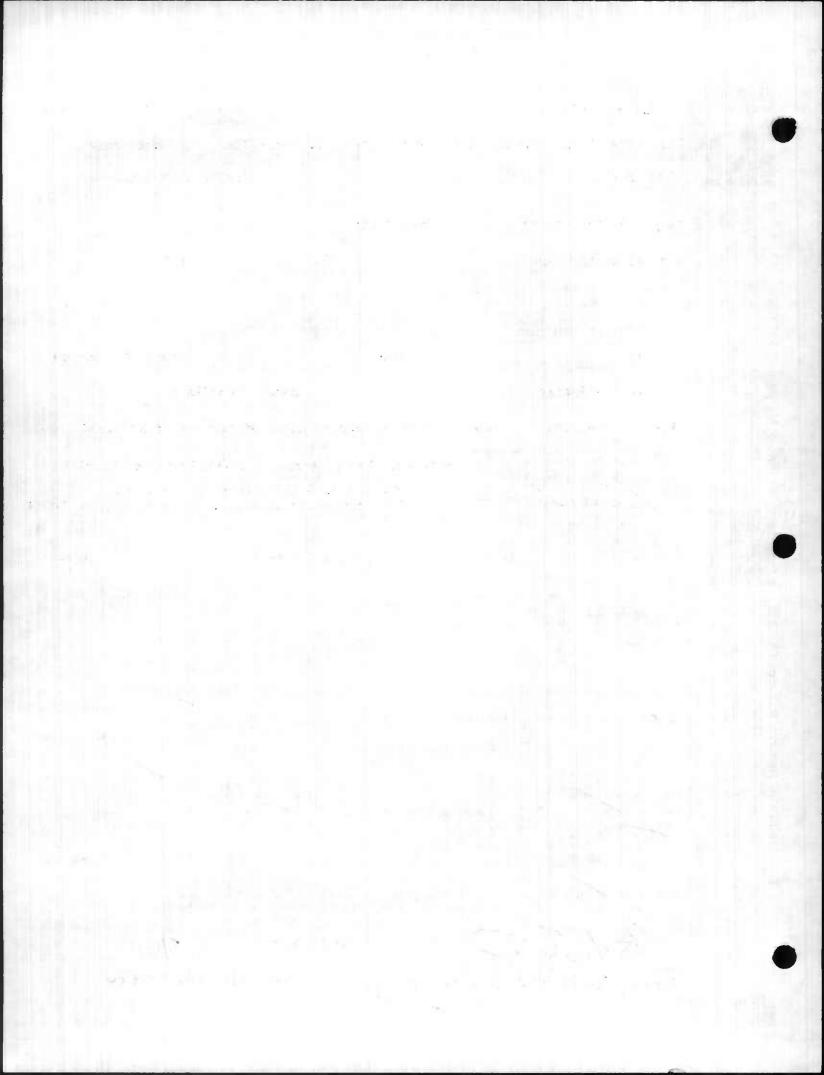
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** D'Aprile Cosimo May 15, 1999 3:30 PM /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Rehabilitation & Nursing Center

5. Social Security Number

6. Sex | 7. Age (In yrs. last birthday) | Months | Days | Months | Days | Months | Days | Months | Days | Months | Days | Months | Days | Months | Days | Months | Days | Months | Days | Months | Days | Months | Days | Months | Days | Months | Days | Months | Days | Months | Days | Months | Days | Months | Days | Months | Days | Months | Days | Months | Days | Months | Days | Months | Days | Months | Days | Months | Days | Months | Days | Months | Days | Months | Days | Months | Days | Months | Days | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Mo Burtonsville
| If Under 24 Hrs. | 8. Da
| Hours | Min. | (M Montgomery Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dev. Year) **Funeral** 1 M 2□ F Director 109-03-7163 Dec. 27, 1909 New York Usual Residence of Decedent the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23s or 28s-f show the Wedical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland | Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 706 Chichester Lane Funeral 14. Race - American Indian, death 20904 12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status e filed within 72 hours after all Hygiene. 1 ☐ Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify P 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 12 Federal Government Engraver traumatic event, permit. Peges 1 and 2 should be file Department of Health and Mental Hy, Important: if item 27 is marked othe any injury or other traumatic event, bncs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vito D'Aprile Anna Costilova 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Victor D'Aprile Silver Spring, Maryland
Date 20c. Location - City or Town, State (son) 706 Chichester Lane 20904 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 5/18/99 Brentwood, Maryland 21. Signature of Eneral Service Licenses 22. Name end Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD, shock, or heart fallure. List only one cause on each line. 20901 Approximate intervel Between Onset and Death **Physician** /Medicai Immediate Cause (Final concer, squamous cell disease or condition resulting in death) 1 year Examiner Due to (or es e consequence of): Examiner physician and the burial-trensit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Due to (or as a consequenca of): P.O. Box 68760 Physician/Medical Due to (or as a consequence of): 80 957 signed by the a d be detached f 23b. Did tobacço usa contributa to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 1 Yes 2 No 3 Probably 4 Unknown artery disease Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s 1 Yea 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Was case referred to medical exeminer? or Attending Physician: funeral director, Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Dey Year) Certification: 27. Manner of Disas 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after deeth. Funeral Director: Al Investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end piece, and due to the cause(s) and manner as stated. edicai completely 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check on one), To the within 2. 29b, Signature 29c. License number 29d. Date signed (Month, Day, Year) 022780 D of person who completed cause of death (Item 23e) (Type, Print) Chr. Dr. Greenbelt, Md. 20770 Schistler MD

State Registrar 31. Dete filed (Month, Day, Year) MAY 1 8 1999

32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month May 18, Day 1999 Physician Jacqueline Rose Dense 12:15 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 6203 Stoneham Road Montgomery Bethesda if Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 28 F Months Days 66 Ohio 296-28-1885 April 1, 1933 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2K No Directo Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6203 Stoneham Road 20817 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 14. Rece - American Indien, Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritai Status Black, White, etc. 1 ☐ Never Married 2 Merried 1 Yes 2 No Specify: by White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Giva kind of work done during most of working lifa. DO NOT use ratired) (Specify only highest grade completed) Elemantary/Secondary (0-12) College (1-4or 5+) Public Health Service Secretary 12 18. Mothar's Nama (First, Middle, Maiden Sumama) 17 Eather's Name (First Middle Last) Alfred Schreiner Rose Cinci 19b. Mailing Address (Straat and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Ralationship (Type, Print) Fred G. Dense/Husband 6203 Stoneham Road, Bethesda, Maryland 20817 20b. Place of Disposition (Name of cemetery, crematory or other placeMay 21, 1999 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 21. Signature of Funeral Service Licensee

22. Name and Address of Facility
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Robert Approximate intervei Batween Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Lung Cancer 3 months Dua to (or as a consequence of): Examiner Lung Cancer 5 years Sequantially list conditions, if any, leading to immediata cause. Enter Underlying Causa (Disaasa or injury that initiated evants resulting in death) Last Due to (or as a consaquence of): Physician/Medical Due to (or as a consequence of): Pert II, Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Breast Cancer A 24b. Were autopsy findings aveilable prior to Completed 24a. Wes an eutopsy completion of cause of death? 1 Tes 2X No 1 ☐ Yas 2 ☐ No 8 25. Was case referred to medical 26. Place of Death (Check only ona) Other: 4 ☐ Nursing Homa 5 ☑ Residence 6 ☐ Other (Specify) 1 Yas 2⊠ No 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Panding 1 | Yes 2 | No Investigation 2 Accident 6 Could not be datermined 3 Suicide 28e. Placa of Injury - At home, ferm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 - Homicida edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29b. Signatur 29c. License number D21531 May 19, 1999 iddress of person who complated causa of death (Itam 23a) (Type, Print)

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**Funeral** 

Director

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Box 68760

P.O.

Division of Vital Records,

Hospital or Attending Physician:

Baltimore, Maryland 21215-0020

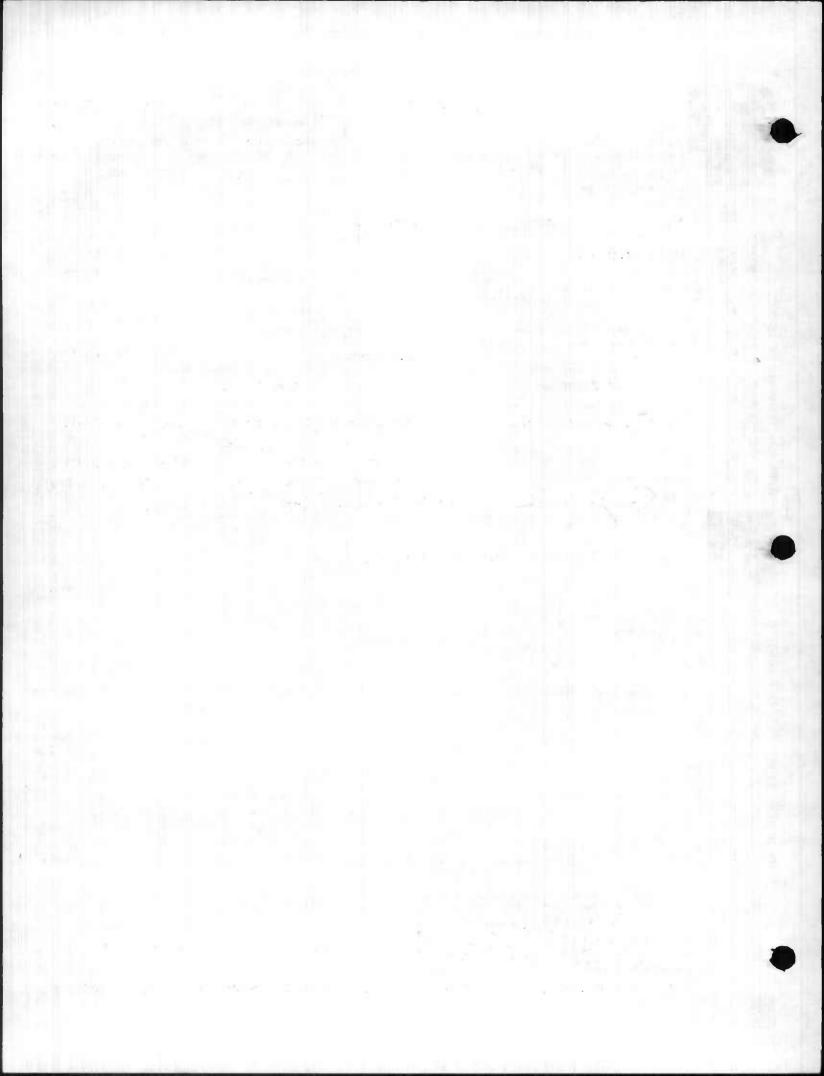
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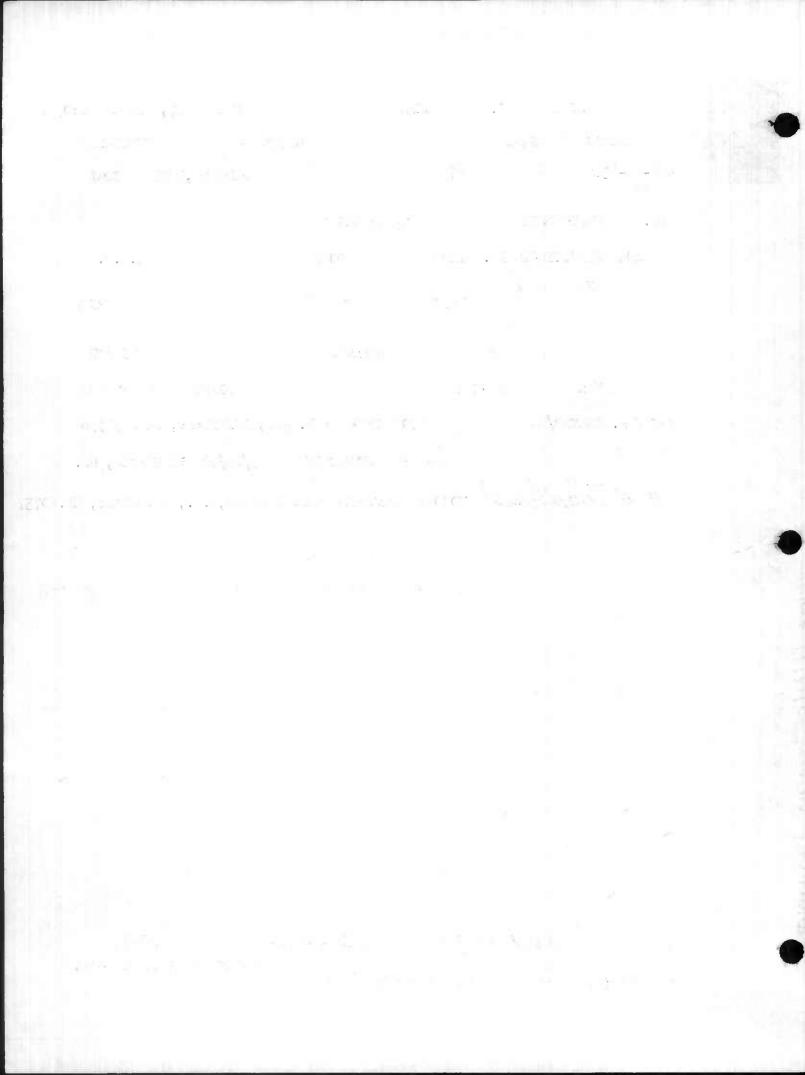
Peter Pushkas, M.D. 31. Date filed (Month, Day, Year) MAY 2 0 1999 32. Pégistrar's Signature 2 course

11510 Old Georgetown Road, Rockville, Maryland 20852



State of Maryland / Department of Health and Mental Hygiene

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5+1		30. Name and address	of person who			m 23a) (Type Betw		Mr	20814	STOEF	DI	3EC	K,	M.D.	
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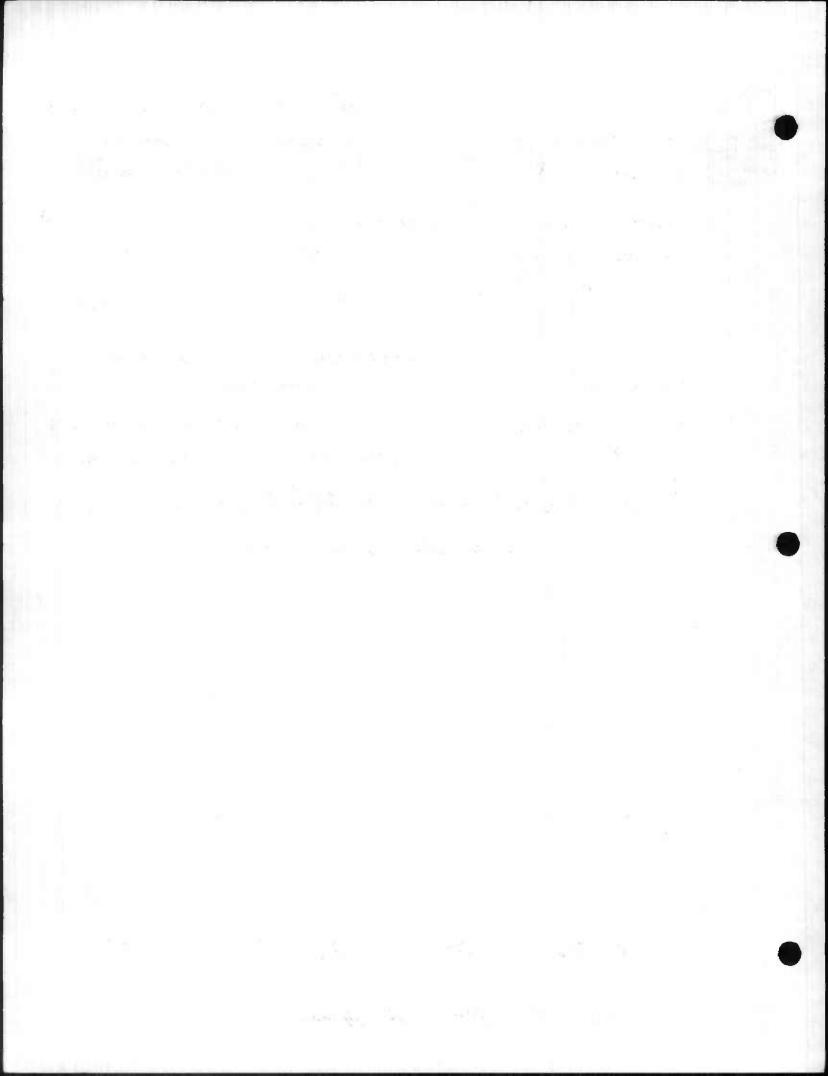
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Physic /Med		Lillian Culle		xon			Month 5	امل	3/9	1145 am
Exam	ner	4a. Fecility Nama (If not institution, giva Alice B Tawes	Straat and number)	Home		Cxisfie	or Location of Dear		of Deeth	+
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yland		Usual Rasidance of Decedant 10a. Stete 10b. County	10	c. City, Town or	Location				10d	. Insida City Limits
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ath with the 23e or 2	Funeral Director	10a. Sireet and Number 46 Somers C	ove Apts.		10f. Zip Coo	21817		10g. Citizan of V		7
and 21215-0020 be filed within 72 hours after death with the Menyland ital Hygiene. d other than "natural", or items 23e or 28e-f show event, the Medical Exactiver must be notified at	by	11. Maritai Status 1 □ Navar Married 2 □ Marriad 3 ☑ Widowad 4 □ Divorced	12. Was Dacadant Eva Armed Forces? 1 ☐ Yas 2 █ No If Yas, Giva Yaar or Datas:	r in U,S. 1:	3. Was Decedant If Yas, specify C	of Hispanic Origin? Cuben, Mexican, Pu No <i>Specify:</i>	(Spacify Yes or No arto Rican, etc.)	Specify	e - Amarican ck, Whita, ato v: Whi	
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teal teal		Anna Dixon Howard  20a. Mathod of Disposition  1 Burlai 2 Cremetion 3 F  4 Donation 5 Other (Spacify)	Ramoval from State	Ob. Place of Dis cemetery, ca	position (Nama or ramatory or other	Pond Driv	Data	dena, MD 20c. Location - Crisfi	City or Town	, Stata
Baltimor pemit. Pages Department of the Important: if the any injury or of page.		21. Signature of Funaral Service Licens Robert H. Brad:	ee law		22. Nama and Ad Bradsha		Funeral	Home		
Physician /Medical Examiner	Examiner	23a. Part 1. Entar the diseasa, or compishock, or heert feitura. List only of Immediata Cause (Final diseasa or condition rasulting in death)	aDue		V D aquance of):				in	fervat Between nsat and Deeth
BOX 68/6U, asth certificate be executed ettending physician and for use as the burial-transit	edical	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or injury that initiated events resulting in death) Last	C. ————	to (or as a cons						
. 70 . 0	Physician/N	Pert It. Other significant conditions con	ntributing to death but no	ot rasulting in tha	undarlying cause	givan in Part I.	23b. Dld	tobacco use coi	ntribute to th	e cause of death?
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Mosp 24 hou Funel letely fil	edical	29e. Cartifiar (Check only one)  Certifying Physical Cartifying Ph	sician: To the best of my ner: On the basis of axa and mannar stated.	knowledge, dea minetion end/or	th occurred at the investigation, in m	time, dete end pla y opinion, deeth oc	ce, and due to the curred et the time,	ceusa(s) and ma dete and place, a	nnar es stete and due to the	d. a cause(s)
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		30. Nema and eddress of person who co Vijay Karum				Highway -	- Crisfie	ld, MD	21817	
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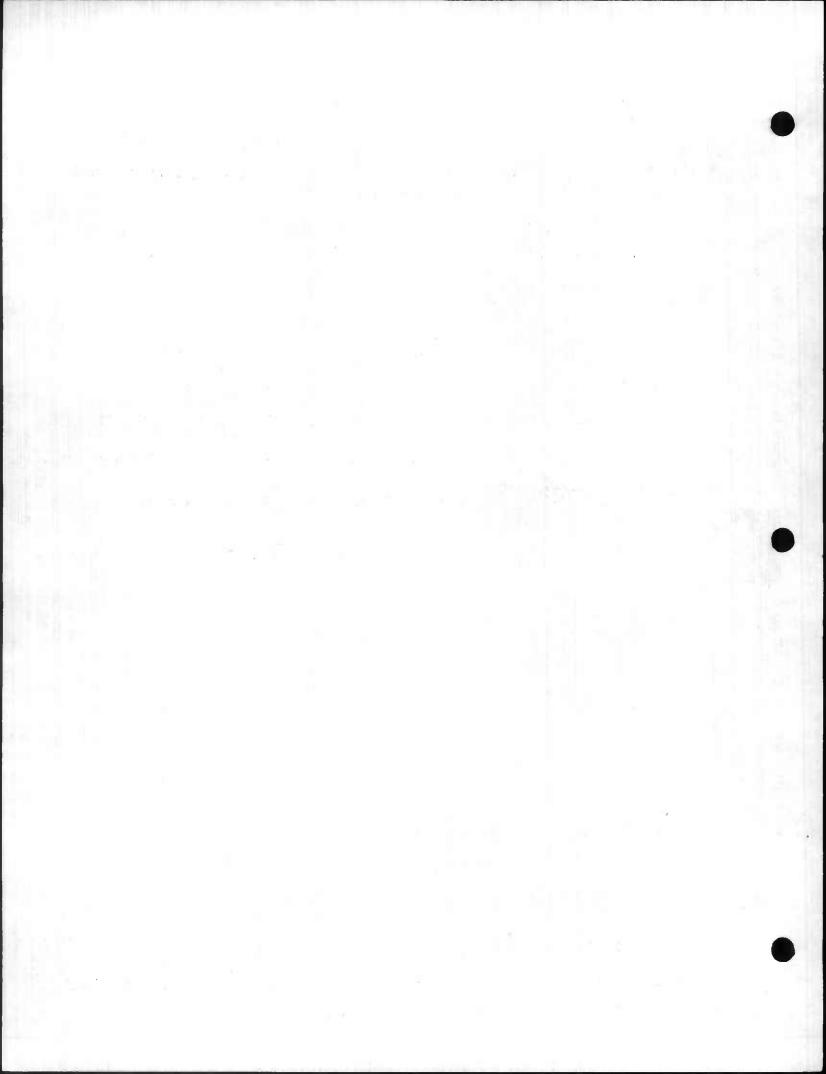
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_				State o	f Maryland		rtment of I tificate of	Health and N Death		ene g g. No.		7458
п	Physici	an	Decedent'a Name (First, Mide	die, Last)		_			2. Date of Death Month	Day	Yeer	3. Time of Death
	/Medi		Robert	L	•	D	itzel		May 15,	<sup>D</sup> 1999		1:10 PM
	Examir	ner	4a. Facility Name (If not Institution 10139 Crab					4b. City, Town, or L Princess		4c. County	of Death rset	
-	Property		5. Social Security Number		7. Age (In yrs. It	ast birthday)	If Under 1 Year		8. Date of Birth	Julie		lace (State or Foreign
	Funeral Director		213-16-0485	1 M 2□ F	76	Yrs.	Months Days	Hours Min.	4/20/192	(gar)	Mary.	lece (State or Foreign try) Land
	P		Usual Residence of Decedent									
	anyla	-	10a. State 10b. Count	•		, Town or Lo					11	0d. Inside City Limits 1 ☐ Yes 2 No
	the M	Director	Maryland Some	rset	Pri	ncess	Anne		100	- Citizen of h	Affin and Courts	
	with with		10139 Crab Isla	and Road				1853	10	g. Citizen of V	USA	try?
	death	Funeral	11. Marital Status	12. Was Dece	dent Ever in U,S	S. 13. y		Hispanic Origin? (Sp pan, Mexican, Puerto	pecify Yes or No-	14. Rac	e - Americ	an Indien,
Maryland 21215-0020	is filed within 72 hours after death with the Maryland all Hygiene.  d other than "natural", or items 23a or 28a-f ahow event, the Medical Examiner must be motthed at	by	1 Never Married 2 Ma 3 Widowed 4 Divorce	II Ves Giv	2 No		Yes, specify Cub		o Ricen, etc.)	Specify	ck, White, o	etc. hite
2-0	72 ho	eted	15. Decede	nt's Education est grade completed)	T	16a. Deced	ent's Usual Occu	pation	kina 1	6b. Kind of Bu	usiness/Inc	tustry
121	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)	life. L	O NOT use retire	during most of world	, in g			
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lan		To Be	Charles Ditzel	,,				Claire			.0,	
ary	#SEE	-	19a. Informent's Name/Relation	ship (Type, Print)		19b. Mailin	g Address (Stree	t and Number or Ru	ral Route Number,	City or Town,	Stete, Zip	Code)
	C = 04 +		Hattie G. Ditze	el/Wife		10139	Crab Is	land Road	, Princes	s Anne	, Md	. 21853
Baltimore,	222		20a. Method of Disposition 1 ☐ Burlal 2 Cremation	3 □Removal from 5	State	metery, cren	sition (Name of patory or other pla	ice)		Oc. Location -	100	
Ë	Pages ment of tant: If th jury or o		4 Donetion 5 Other (		Sali	Lsbury	Cremato	ry	5/17/99 <sup>9</sup>	Salisbu	ıry, î	1d.
3al	permit. Page Department of Important: If any Injury or once.		Signature of Funeral Service	Licensee			Name and Addr	ess of Facility neral Hom	0			
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	Dhualalaa		Part1. Enter the disease, or heart feilure. Lis			_						Approximate Interval Between Onset and Death
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	Examiner		disease or condition resulting in death)	е		es e conseq			/ ( •	7	1	7
	be sit	iner		<b>a</b> b							(	
	daath certificate be executed e attending physician and ed for use as the bunal-transit	Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury		Due to (or	as a conseq	uenca of):					
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9		ledi	resulting in death) Lest		Due to (or	as a consequ	ience or).				-	
Вох	th cer endin	Physician/Me		d							<u> </u>	
	the att	sici	Part II. Other significant conditi	ions contributing to de	ath but not resul	lting in the ur	derlying ceuse gi	ven in Part I.	23b. Did tob	acco uae co	ntribute to	the cause of death?
P.0	that the death certified by the attending deteched for use a								1 🗆 Ye	2 □ No	3 Prot	pably 4 Unknown
ds,	S 50	d by							24a. Was an	autoneu	24h We	ere autopsy findings
COL	7 7 0	lete							perform	ed?	ava	allable prior to mpletion of cause
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n o	tending Phieath.		27. Mapner of Deeth  1) Netural 5 ☐ Pendi	28a. Date o	f Injury h, Day Year)	28b. Time of Injury	28c. Inju Wo	ry et ork?	28d. Describe how	v injury occur	red	
sio	Attending r death. actor: Attai	catl	2 Accident invest	igation			M 1	Yes 2□No				
	in Diffic	Certification:		mined 286. Pleca	of Injury - At hor ig, etc. (Specify)	ne, farm, stre	et, factory, office		281. Location (Stre City or Town,	et and Numb Stete)	er or Rura	l Route Number,
_	To the Hospital or Aff within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier 1 Cartifyi	ng Phyalctan: To the	best of my know	ledge, death	occurred at the ti	me, date and place	and due to the car	use(s) and me	nner se et	ated
	Ne Horn 24 h	edicai	(Check only 2 Medical one)	Examiner: On the ba and mann	sis of examination	on end/or inv	estigation, In my	opinion, death occur	red at the time, dat	e and place,	end due to	the ceuse(s)
	Withi To th	N	29b. Signeture end title of certific	er	1		29c. Licen			d. Date signe	d (Month, I	Dey, Yeer)
			· CH	gum	mo		D	2521	7 5	217.	-97	
			30. Name and address of person	o completed cause	of deeth (Item	23a) (Type, I	Print)		1.5		-	
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	Sta Registr			7 1999	Seren	2	. Spo	ch				



State of Maryland / Department of Health and Mental Hygiene

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eral tor	06	3-32-8755 el Residence of Decedent	6. Sex	60 60	s. last birthday) Yrs.	Months		Hours Min	Jan. 26	y, Year)	New Yo	o (State or Fore
	-	State 10b. County		10c. C	City, Town or Lo	ocation					10d.	fnside City Limi
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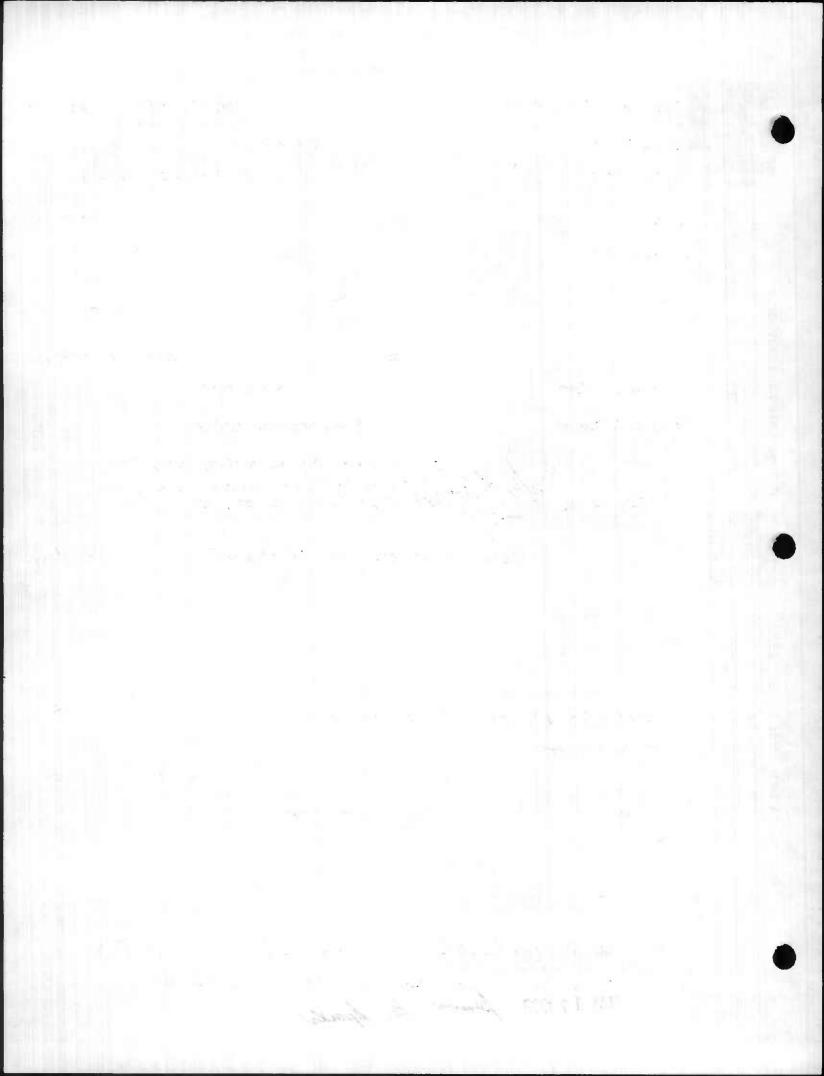
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month May 14, 1999 **Physician** Loretta Killman Edelen 2:45p.m. /Medical 4a Facility Nama (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Chestertown

If Under 24 Hrs.
Hours Min.

8. Date of Birth
(Alonto, Day, Year) Heron Point Kent If Undar 1 Yaar Birthplaca (Stata or Foreign Country) 5. Social Sacurity Number 6 Sax 7. Age (In vrs. last birthday) **Funeral** 10 M 20 F Months Days Yrs Director 212-07-4029 Usual Residence of Decedant August 15, 1907 Maryland with the Maryland permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylan Depertment of Haalth end Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any highry or other traumatic event, the Modical Examinational Indiffes and once. 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits Yas 2□No Directo Maryland Kent Chestertown 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 213 Heron Point 21620 United States Funeral 14. Race - American Indian. 11. Marital Status 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) Black, Whita, atc. 1 □ Navar Married 2 □ Married altimore, Maryland 21215-0020 1 ☐ Yas 2XXNo Specify: à 3XWidowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada completed) Elementary/Secondary (0-12) Collage (1-4or 5+) Bookeeper Bookeeping / Accounting 18. Mothar's Nama (First, Middla, Maldan Sumama) 17. Fathar's Nama (First, Middla, Last) Be Charles L. Killman Mary E. Poeblitz 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Addrass (Straet and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Frederick H. Stalfort 1331 Main Street, Hampstead, Maryland 21074 20b. Place of Disposition (Nama of camatery, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Date 1 ☐ Burial 2 Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Chesapeake Cremation Ctr. LLC 5/16/99 Chester, Maryland 21. Signature of Funaral Service Lice 22. Nama and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. William L. King. Jr. 130 Speer Road, Chestertown, Maryland 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of the death. Approximate Intarval Between Onset and Death **Physician** /Medical Immadiata Causa (Final 8 days CEREBROVASCULAR ACCIDENT disaasa or conditio rasulting in daath) Examiner Examiner physician end s the burief-trans Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of): certificete be execu Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequance of): 80 usa Por Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? ed by the e signed by t 1 Yas 2 No 3 Probably 4 Unknown CONGESTIVE HEART FAILURE ð 24b. Were autopsy findings available prior to complation of causa of daath? 24a. Was an autopsy Completed DEMENTIA pega 2 1 □ Yas a No 1 Yas 2 No certificate or Attending Physician: funeral director, 25. Was casa rafarred to medical axaminar? Be 26. Placa of Death (Check only ona) Othar: Nursing Homa 5 Rasidanca 8 Othar (Specify) 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? 1) Natural 2 Accident 5 Panding 1 ☐ Yas 2 ☐ No 24 hours after death. Invastigation 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At home, farm, straet, factory, office building, atc. (Specify) Location (Straat and Number or Rural Routa Number, City or Town, Stata) filled in by 4 ☐ Homicida Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and due to tha causa(s) and mannar as stated.
2 Madical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at tha time, data and place, and due to the cause(s) 29a. Certifiar Medical (Check only one) and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of certifiar 29c. Licansa number A Note MID 41581 10 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) Helen A. Noble, 122 Speer Road, Suite 5, Chestertown, Maryland 21620

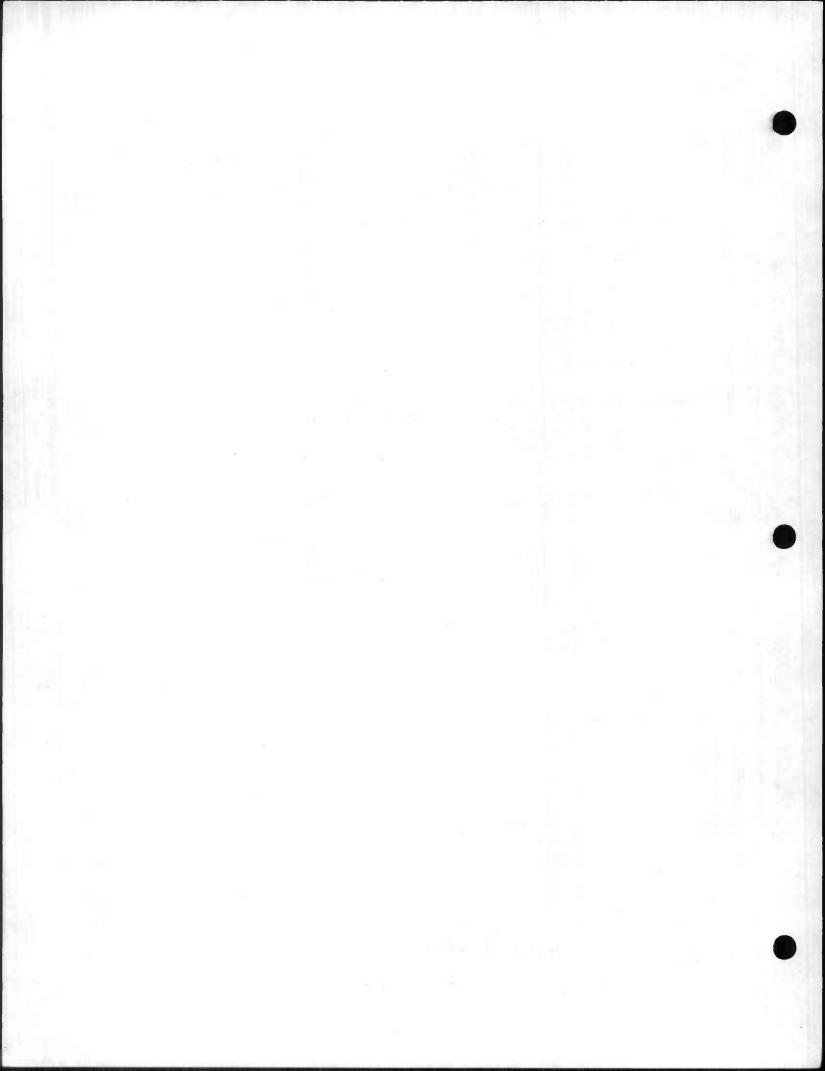
State Registrar 31. Date filed (MoM.A. Yar) 1999

32. Registrar's Signatura



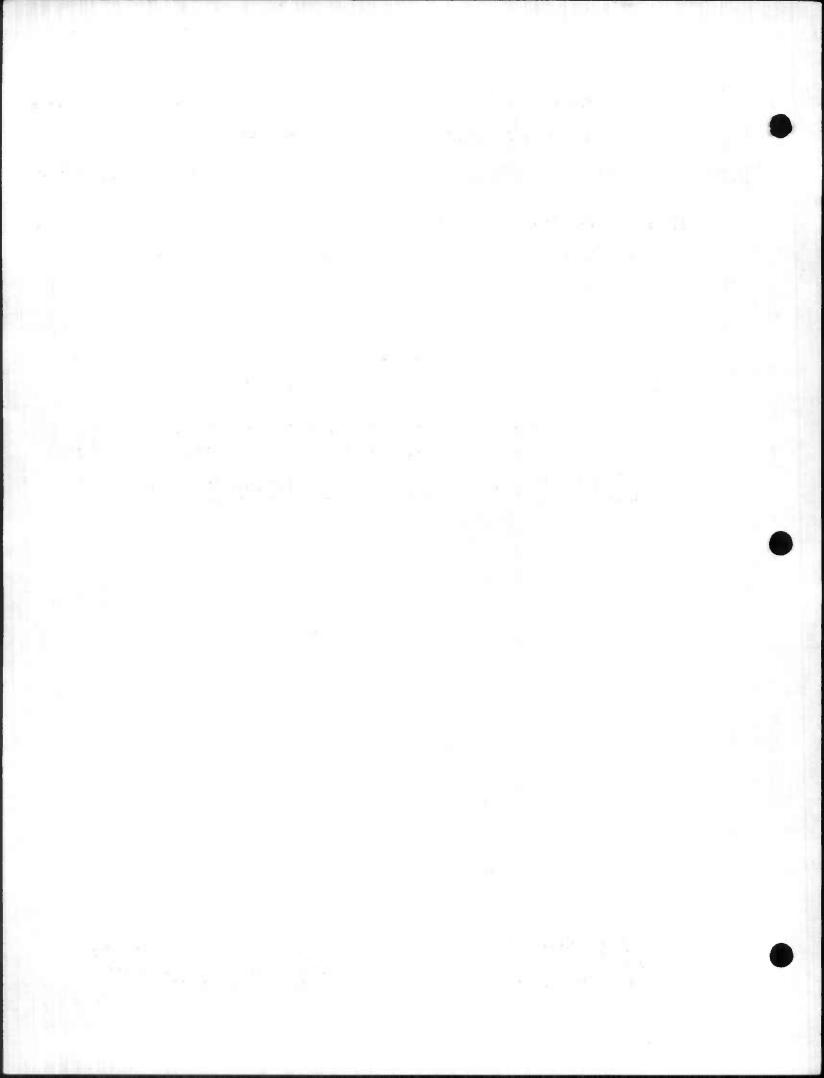
## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ก	1. Decedent's Nar	ne (First, Middle,	Last)			DC HI W		2. Date of Dea		3. Time of Dea
	Exemple	oo C E	ninosa					Month 1	Day	Year 999 7:30 Al
al er	4a Facility Name	(If not institution,	give street and	d number)			4b. City, Town, o	May 1 -		
		witt Ave					Silver St	wina		
7	5. Social Security		B. Sex		In yrs. last birthday	If Under 1 Ye	ar If Under 24 H	s. 8. Date of Birth	Montgo	
	074-48-0 Usual Residence		1፟፟£ M 2□	F	90 Yrs.	Months Day	ys Hours Mi	Nov. 1,		9. Birthplaca (State or Fo Country) Nicaragua
-	10a. State	10b. County		10	Oc. City, Town or La	ocation				10d. Inside City Li
	Maryland	Montgo	omery		Silver S	Spring				1 ☐ Yes 2 🛭
	10e. Street and No	umber				10f. Zip Cod	0		10g. Citizen of V	What Country?
	3352 Hew	itt Aver	nue #20	)1		20	906		USA	
İ	11. Marital Status		12. Was	Decedent Eve od Forces?	er in U,S. 13.	Was Decedent of	of Hispanic Origin? Juban, Mexican, Pue	Specify Yes or No-	14. Rac	e - American Indian, ck, White, etc.
	100000000000000000000000000000000000000	rried 2€ Marrie 4 ☐ Divorced	d 1 TY	res 2⊠ No s, Give or Dates:		t∳ Yes 2□N	to Specify:		Specify	y:
ŀ		15. Decedent's			16a. Dece	dent's Usual Oc	Nicaragua Gupation	an	16b. Kind of Bu	White usiness/industry
ŀ		cify only highest	grade comple	-	(Give	kind of work do DO NOT use ret	ne during most of w	orking		,
l	Elementary/Sec	condary (0-12)	Colle	ge (1-4or 5+)	Cle	rk			Cleric	a1
ŀ	17. Father's Name	(First, Middle, Li	ast)		, otel	LA	18. Mother's N	ame (First, Middle,		
	Lorenzo	Espir	2063				Ange	la Meji	2	
-	19a. Informant's N	-		)	10h Maili	ing Addrage /Stn				State, Zip Code 20906
	_	CONTRACTOR PROCESS								
ŀ	Socorro 20a. Method of Dis		nosa	(wife	20b. Place of Dispo		Avenue #2	Date Date		ng, Maryland City or Town, State
ı	1X Burial 2	Cremation 3			cemetery, cre	matory or other p	olace)	) Date	Ecc. Eccation	Ony or rown, State
		5 ☐ Other (Spe	_					5/17/99	Silver	Spring, Maryl
	21. Signature of F	uneral Service Li	oprisale			2. Name and Ad	dress of Facility  Collins	Funoral	Homo	Inc
	IKA	ran A -	Strve	u			rsity Bly			
+	23a, Part1. Enter	the disease, or o	omplications th	hat caused the			tying, such as cardi			Approximate
1	shock, or he	art failure. List or	nly one cause	on each line.						Interval Between Onset and Deat
1	Immediate Cause	(Finat								
	disease or conditi resulting in death)	on	a. Con		e Heart 1	Failure				1 Hour
1						AND THE RESERVE OF THE PARTY OF				1 11041
Н					e to (or as a conse	quence of):				1
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	Sequentially list of any, leading to it	onditions, mmediate	ь. Мус	cardia		quence of):				
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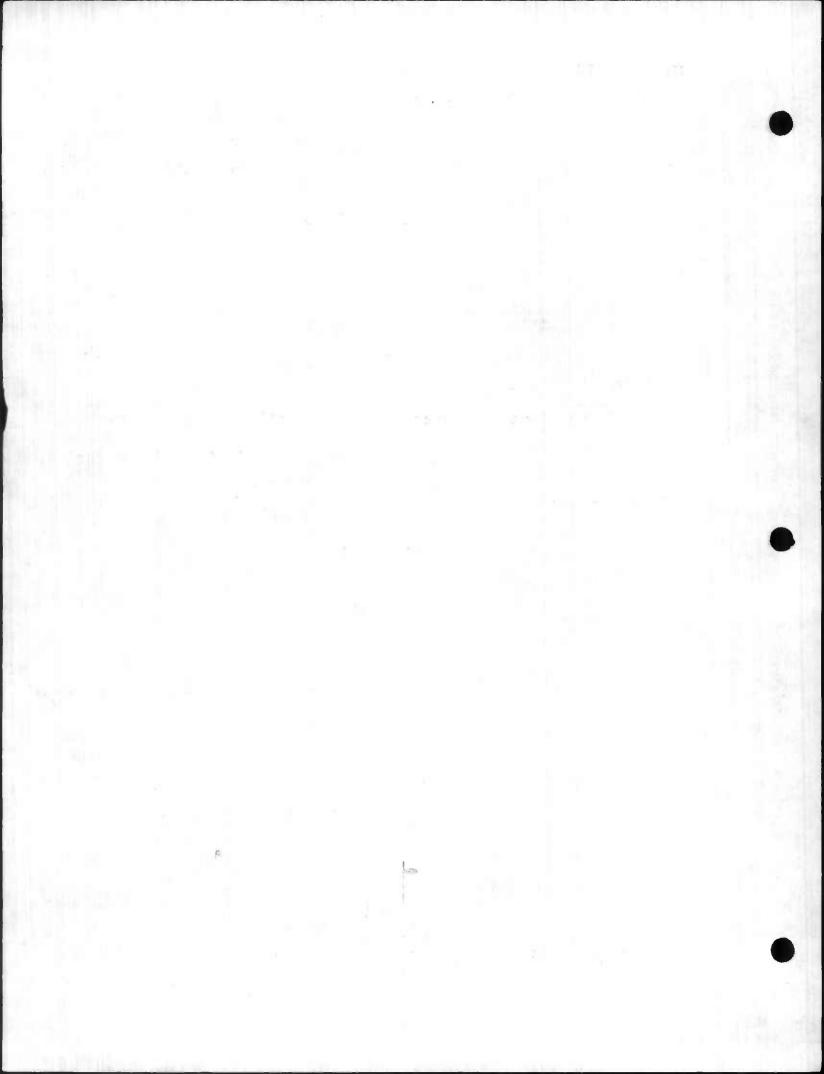
State of Maryland / Department of Health and Mental Hygiene

						Cer	tificate	of Death	F	Reg. No.	3	1462
	Physic		Decedant's Nama (First, Middle, La NANET)		EV.	ANS			2. Data of Dec Month MAY	Day	Year 99	3. Time of Death 8:40 PM
þ	/Medi Examii		4a. Fecility Neme (If not Institution, given NATIONAL NAVAL N					4b. City, Town, or BETH	Location of Death	4c. Count	-	
N.	Funerai Director			Sex 7. Ag		last birthday) 5 Yrs.	If Under 1 \ Months D	'ear If Under 24 Hr ays Hours Mir		h v, Year) 1944		lece (Stete or Foraig try) IMORE, MD,
	seath with the Maryland no 23e or 28e4 show must be notified at	lor	10a. Steta 10b. County	TAN		y, Town or Loc	cation				16	0d. Inside City Limit
	r 28a notifi	Director	VIRGINIA ARLING 10e. Street and Number	IUN	AKL	INGTON	10f. Zip Co	de		10g. Citizen of	What Coun	try?
	th wit		224 NORTH IRVING	STREET			2220	01		UNITED	STAT	ES
020	after or the	by Funeral	11. Merifel Status  1 Nevar Married 2 Merried  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Giva Yeer or Detes:			Ves Deceden Yas, specify	of Hispenic Origin? ( Cuban, Mexican, Pue No Specify:	Specify Yas or No- rto Rican, atc.)	14. Rad Ble Specifi	ce - Amarica ck, White, e WHI	
Maryland 21215-0020	bin 72 hours an "natural", Medical Exa	Completed	15. Decedent's E (Specify only highast gri	ducation ada completed) College (1-4or	5+)	16a. Deced (Give I lifa. D	ent's Usuel C kind of work o OO NOT use r	ccupation lona during most of we etired)	orking	16b. Kind of B	usiness/Ind	lustry
2	ygien ygien rt the	Con		4	- ',	TEACHE	ER					EDUCATION
and	ntal H ad off	Be	17. Fethar's Name (First, Middle, Last GEORGE W. GRANO						ame (First, Middle,	Maiden Surnar	na)	
J.	shoult mark mark	2	19e. Informent's Neme/Reletionship			19b. Meliin	a Address (S	VIOLA .		r. City or Town	Stata Zin	Coda)
ž	amb a 27 in er trau		SAMUEL E. EVANS									
Baltimore,	artment of He ortants if flem injury or others.		20a. Method of Disposition  1 Buriai 2 CCramation 3 4 Donetion 5 Other (Special	Removel from Stete	20b. P	Piece of Dispos Semetery, Franc EMATION	sition (Neme patory or othe ENT	RVING STRE DI ER ER	Dete 5/14/99(	20c. Location	- City or To	wn, State IRGINIA
Balt	Departiment import any injury		21. Signature of Fagerat Service Lice	100 lag	D, C	ST 45	510 WII	ddrass of Eacility . MURPHY .SON BLVD.	ARL. VA. 2	22203	С.	
			23e. Pert1. Enter the disease, or com shock, or heart failure. List only	pleations that cause one cause on each i	deetl	h. Do not ente	or the mode o	dying, such es cardie	ec or respiretory an	rest,		Approximate Interval Between
	Physician /Medical Examiner		Immediete Ceuse (Final disease or condition	META	ے ASTAT	CIC BRE	AST CA	NCER				Onset and Death
		Iner	rasulting in death)		Due to (o	or es e consequ	uence of):					
ó,	rificate be axecuted ng physician and as the burial-transit	Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Undertying Cause (Diseese or injury that initialed events	b. —————	Due to (o	or as e consequ	uence of):					
x 68760,	5 0 6	/Medical	that initiated events resulting in deeth) Last	d	Due to (o	r es a consequ	ienca of):					
Вох	or the	cian	Post II. Other algoldisent conditions			ulala a la ali a un	de Adeles e e e		00h DI44			Ab
P.O.	that the ed by th detach	by Physician/N	Part II. Other significant conditions of	onthouting to deeth o	ut not res	uiting in the un	denying caus	e given in Pert I.				the causs of death
Records,	aw requi	Completed b							24e. Wes o		COL	ore autopsy findings ullable prior to appletion of cause death?
	The ate h	Con							1□ Y	as 2 No	1	Yas 2 No
of Vital	Physician: The this certificate ral director, par	Be	25. Wes case referred to medical axaminer?	Hospitel: V-				Other	eth (Check only o			
	D 00 Z	1: 70	1 ☐ Yes 2X No 27. Mennar of Deeth	Hospitel: 12 Inpatie		ER/Outpatient 28b. Time of			Home 5 Resid			)
o	Attending Is death.	ation	1 X Neturel 5 ☐ Pending Investigation	(Month, De	y Year)	Injury	М	Injury ef Work? 1 Yes 2 No				
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Sulcide 6 Could not be determined		ury - At ho c. (Specif)	ome, ferm, stre	et, factory, of	fica	28f. Location (S City or Tow	itreet and Numi n, State)	ber or Rura	Route Number,
	e Hospit n 24 hour e Funera pletely fill	edical	29a. Certifier 1 Certifying Ph (Check only one) 1 Madical Example 1	nysician: To the best miner: On the basis of end menner st	f examinat	wledge, deeth tion end/or invo	occurred et t estigetion, in	ne time, dete and piec my opinion, deeth occ	e, end due to the curred et the time, c	eusa(s) and m lete and plece,	and due to	eted. the cause(s)
	To the To the Comp	X	29b. Signeture and title of cartifier	A			29c. Li	cense number	1	29d. Date signe	d (Month, l	Day, Year)
	12		I full the	1 MD			MD-	18870 (DC)	)	13 N	1449	9
	•		30. Neme and eddress of person who		leeth (Item	23a) (Type, F		NATIONAL N			NTER	
			J.M.HILL, LCDR, N 31. Dete filed (Month, Day, Year)		arla Ci	dura	<u>.</u>	BETHESDA M	D 20889-	5600		
	Sta	-	5.5 0.5 0.00 0.00	32. Registr	or s Signe	LUTO L	-1					



SANGAY FLEETWOOD	ITEMS: #23 PART I, 27	State of Maryland / I			99	171.00	
Physician	1. Decedent's Neme (First, Middle, Las SANGAY HER			2. Da Mc	Reg. No.	Year 3. Time of Death 99 7:36P.M.	
/Medical Examiner	An English Name (II not institution at a	street and number)	-	4b. City, Town, or Location CAMP SPRINGS	Location of Death 4c. County of Death		
Funeral Director	5. Social Security Number 215-02-7644 6. Security Number 11		V 10 10 10 10 10 10 10 10 10 10 10 10 10			9 Birthplaca (State or Foreign Country) N. Carolina	
with the Maryland a or 28a-f show be notified at	Usual Residence of Decedent  10a. Stete 10b. County  MD Prince (	10c. City, Tow	m or Location			10d. Inside City Limits 12☐ Yes 2☐ No	
desth with the Maryla rms 23s or 28s-f shor r.mat be notified at	10e. Street end Number		10f. Zip Code 2 0		10g. Citizen of V		
_ 1 4 5 2	3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes:	13. Was Decedent of H If Yes, specify Cube 1 ☐ Yes 2 ☑ No	lispanic Origin? (Specify Yo an, Mexican, Puerto Rican, Specify:		e - American Indian, ck, White, etc. y Black	
Maryland 21215-0020 d2 should be flied within 72 bours at th and Mental Hygiens Toburs at 18 mented other than "natural, or treumstic event, the Medical Exam To Re Completed by 1	15. Decedent's Edi (Specify only highest grad Elementary/Secondery (0-12)	cation 16a Completed) College (1-4or 5+) 4 VYS	Decedent's Usuel Occup (Give kind of work done life. DO NOT use retired Student	ation during most of working f)		usiness/industry	
yland Suid be filed Mental Hyg	17. Father's Neme (First, Middle, Last) Winfred L. F.	Leetwood		18. Mother's Neme (First, Tonia	Middle, Maiden Sumam Okyne	96)	
C = N L	19e. Informent's Neme/Reletionship (7) Tonia Okyne F	Leetwood (Moth	er) 6703 (	Cherryfield	Rd., Ft.	Stete, ZMMPGode)20744 Washington, City or Town, State	
Baltimore, semit. Pages 1 a Department of Nes Temportants if then my injury or other ance.	1 ☑ Burlel 2 ☐ Cremation 3 ☐ I 4 ☐ Donetion 5 ☐ Other (Specify, 21. Signal was of Funerel Service Long	Gate Gate	of Heaven  22. Name and Addre	Cem. 5/22	2/99 Silv	ver Spring,MD	
W 44148	23 Part I. Enter the disease, or comp shock, or heart eiture. List only o	licetions thet caused the deeth. Do ne cause on each line.	ROCKVIL	•	350	Approximete Interval Between	
Physician /Medical Examiner	fmmediete Cause (Finel disease or condition resulting In death)	PULMONARY	TUBERCULOSIS consequence of):			Onset and Death	
death certificate be executed the attending physician and office as the burial-transit sician/Medical Examines		с	consequence of):				
P.O. Box 68 at the death certifica t by the attending ph etached for use as th	resulting In deeth) Lest	d					
P.O. d by th detache		ntributing to death but not resulting i	in the underlying cause giv	ren in Part I. 2	3b. Did tobacco use con	ntribute to the cause of death? 3 □ Probably 4 ⊡ Unknown	
Record  law requir  has been s  ge 2 should  mpleted				24	4a. Wes an autopsy performed?	24b. Ware eutopsy findings evailable prior to completion of cause of death	
Of Vital   Physician: The this certificate ral director, page 1. To Be Co	25. Was case referred to medical axaminer?	Hospitel: 1 ☐ Inpetient 280€R/O	utpatient 3 DOA Oth	26. Place of Deeth (Checker:	1 res 2 No ck only one) □ Residence 6 □Oth	152TYes 2□ No	
ision thending death. ctor: After fune fune floation floation	27. Menner of Death 1 🖾 Netural 2 Accident 3 Suicide 4 Homicide  27. Menner of Death 5 Panding investigation 6 Could not be determined	28e. Dete of Injury 28b.	Time of thiury Mor	Yes 2 □ No 28f. Lo	escribe how injury occur ecation (Street and Numb ty or Town, State)	red  per or Rural Route Number,	
Div To the Hospital or / within 24 hours after To the Funcral Dire completely filled in b	29e. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sicien: To the best of my knowledgener: On the bests of examinetion are and manner steted.	e, death occurred at the tin nd/or investigation, in my o	ne, date and place, and du pinion, deeth occurred et the	e to the cause(s) end ma he time, date end plece,	anner es stated. and due to the cause(s)	
To the To the Comp	29b. Signeture and title of certifier	tane, M	D. 29c. Licens		29d. Dete signed MAY 13,1	d (Month, Day, Year) 999	
State	30. Neme and address of person who co	perpleted cause of deeth (Item 23a) PESTONE(I 32. Registrer's Signeture	111 D	Street, Bal	timore, Mar	yland 21201	
Registrar	MAY 1 7 199		B. Some	61			

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day **Physician** SARAH MAE FORD 12:15 PM May 9, 1999 /Medicai 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 88 Somers Cove Apts. (residence) Crisfield Somerset If Under 1 Year If Under 24 Hrs. 5. Social Sacurity Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funera** 1□M 2**X**F Days Min. Months Hours 78 Yrs 220-28-0333 March 4, 1921 Director Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 28a-1 show 10d. Inside City Limits if than "naturel", or items 23a or 28a-1 show the Wedical Examiner must be notified at 1 Yes 2 □ No Director Crisfield Maryland Somerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 88 Somers Cove Apts. 21817 23a USA Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 € No if Yes, Give Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian, Pages 1 and 2 should be filed within 72 hours after or nent of Haalth and Mental Hygiena. nt: If item 27 is marked other than "naturel;, or iter Bleck. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify Specify: White by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Frozen Food Mfg. Bookkeeper 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Christopher Tyler Lillie Tyler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 s Department of Haalth ar Important: If item 27 ia any injury or other trau once. Donald G. Ford (son) 73 Richardson Ave.-PO Box 587- Crisfield, MD 21817 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cramation 3 Removal from State 5/11/99 Asbury Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Crisfield, MD 22. Nama and Address of Facility

Bradshaw & Sons Funeral Home 21. Signature of Funaral Sarvice Licensas Conhete. Denne Cere 306 W. Main St. - Crisfield, MD Robert H. Bradshaw 21817 23a. Part1. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medical Immadiate Causa (Final disease or condition resulting in death) G I BLEEDING minutes Examiner Due to (or as a consequence of): Examiner COPD months physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): Box 68760 ASCVD years Physician/Medicai Due to (or as a consequence of) 88 attending use jo P.O. Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? á 1 Yes 2 No 3 Probably 4 Unknown signed to Records. þ 24b. Were autopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy performed? page 2 2 No 1 ☐ Yes 2 No certificate of Vital Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this funeral 28e. Dete of Injury (Month, Day Year) Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Division or Attending 1 Neturel 5 Pending death. 1 Yes 2 No ours aftar death. eral Director: A filled in by the fi Investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital of within 24 hours all To the Funeral D completally filled 1xCartifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signatura and title of certifian 29c. License number 29d. Date signed (Month, Day, Year) D 48098 May 11, 1999 30. Name and address of person who completed cause of death (item 23e) (Type, Print) Vijay Karumbunathan, M.D. - 201 Hall Highway - Crisfield, MD 31. Date filed (Month, Day, Year) 32. Registrer's Signature State WAY 1 4 1999 Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Nama (First, Middla, Last) Month Year **Physician** 2:04 1999 mal 18, Anna Margaret Grimm /Medical 4b. City, Town, or Location of Ceath 4a Facility Name (If not institution, giva street and number) 4c. County of Death **Examiner** Hagerstown

If Undar 24 Hrs. 8. Data of Birth
Hours Min. (Month, Day, Year) Washington County Hospital Washington Birthplaca (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Months 1□ M 2□XF 88 Director 225-14-1974 March 2, 1911 Virginia Usual Rasidenca of Deceden the Maryland 10a. Stata 10c. City. Town or Location 10d. Insida Cltv Limits 10b. County r than "natural", or items 23a or 28a-1 show the Medical Exampler must be notified at 1 Yes 2 No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be flied within 72 hours after death with near of Health and Mental Hygiene.
In It If lean 27 is marked other than "natural; or items 23a or with If lean 27 is marked other than "natural; or other treumatic svent, fire Maginal Estimates in matter.

Inty or other treumatic svent, fire Maginal Estimates in matter. 12703 Greencastle Pike U.S.A.

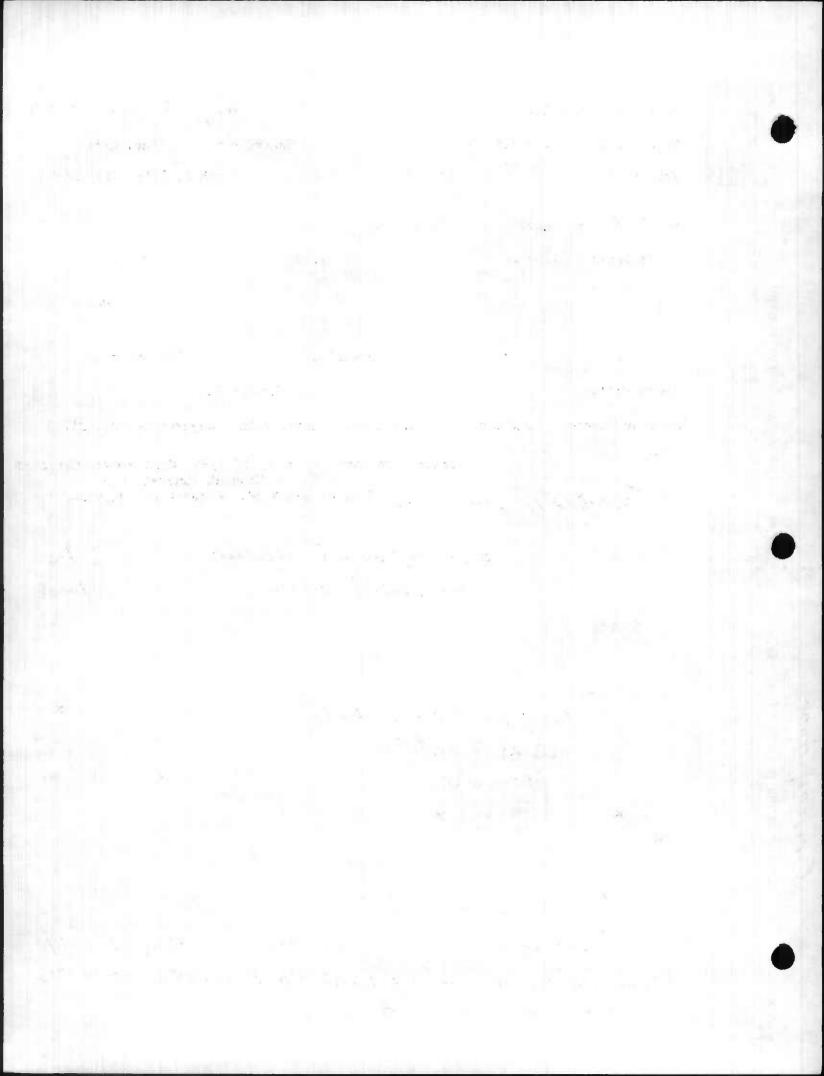
14. Race - Amarican Indian,
Black, White, etc. 21740 Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-lt Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Giva 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: by 3 ☑ Widowed 4 □ Divorced White Completed 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 n Her own home 17. Father's Name (First, Middle, Last) 18. Mother'a Name (First, Middle, Maiden Sumeme) Be James Rhodes Luella Gum 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. intormant's Name/Relationship (Type, Print) Dorothy Rhoton - Daughter 12703 Greencastle Pike Hagerstown, Md. 21740 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of important: If it eny injury or o 1 XBurial 2 Cremation 3 Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Memorial Park 5/21/99 Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland unull 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert tailure. List only one ceusa on each line. Approximete Interval Between Onset and Death **Physician** Acute Myocardial infanction

Due to (or as a consequence of):

Coronary Arleny Disease /Medical Immediate Ceuse (Finat disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed physician and s the bunst-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Undarlying Cause (Diseasa or injury that initiated events resulting In death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) d for use as t signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributs to the cause of death? Congestive Heart Failure 1 Yes 2 No 3 Probably 4 Unknown p 24b. Were autopsy tindings available prior to completion of cause ot deeth? should b atrial Februllation 24e. Wes en eutopsy Completed s certificate has b 1 Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: Be 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ FR/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 10 this 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending death. 1 Yes 2 No investigation or Attendation of the deat 6 Could not be determined 3 Sulcida 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) 124 hours after the Funerel Directles detely filled in b 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title ot certitier 29c. License number May 19, 1999. D44996 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

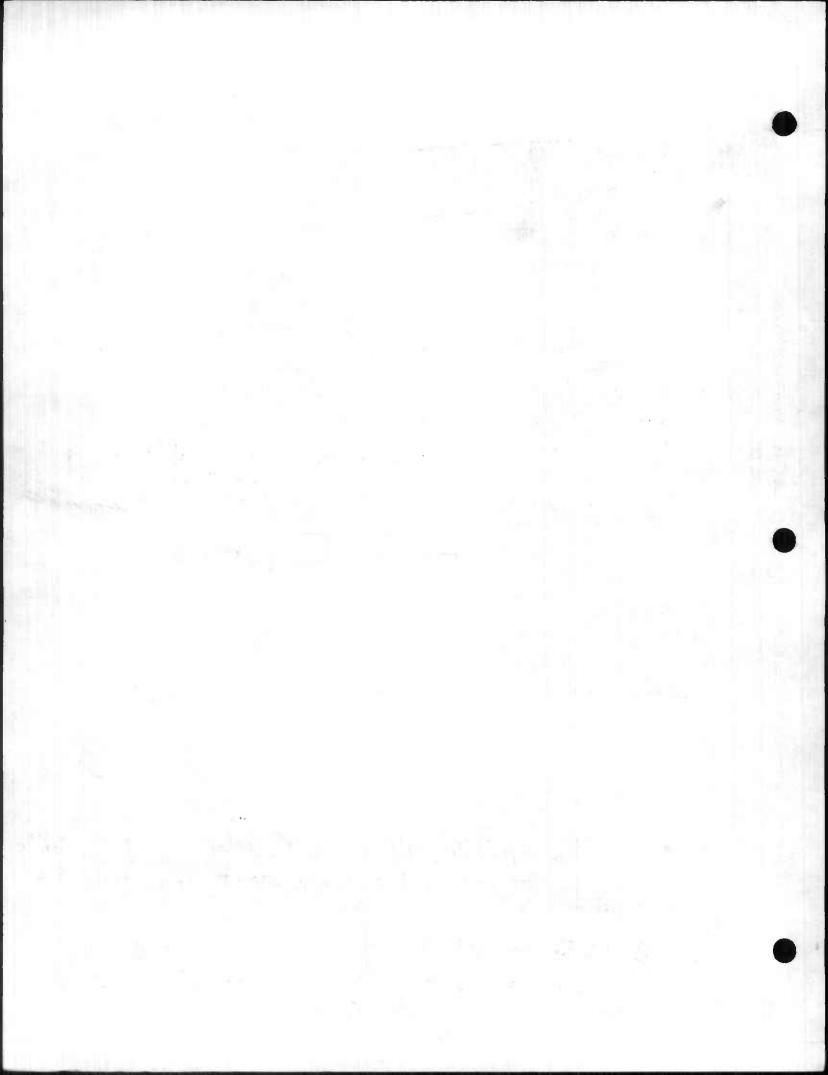
2AFAL MALIK MD 20311 LAPPANS RD BUDNSBORD MB 21713. 32. Registrar's Signature 31. Date tiled (Month, Dey, Year) State MAY 2 0 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene

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mber Gror	Certificate of Death		eg. No.	, , , , , , , , , , , , , , , , , , , ,
Physicia	1. Decedent's Name (First, Middle, Last)	2. Dete of Deat Month		3. Time of Death
/Medic	ANDER EGGISE GROFT	May 1		2:28 A.M.
Examine	4a Facility Name (If not institution, give street and number) 4b. City, Town, or Lo	cation of Death	4c. County of	Death
	Johns Hopkins Hospital  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	ore	N/	
Funeral Director	634-26-2900 1 M 201F 10 Yrs. Months Days Hours Min.	8. Dete of Birth (Month, Day, JUN 23,	1988 A	B. Birthplace (State or Foreign Country) Abilene, TX
ykand Maria	10a. State 10b. County 10c. City, Town or Location	ROTE .		10d. Inside City Limits
Part a	PA Adams Fairfield  10e. Street and Number  107. Zip Code 17320			1 No Yes 2 No
		1	0g. Citizen of Wr USA	at Country?
3 48	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U,S. Armed Forces? 1 Yes, Give Year or Dates:  13. Was Decedent of Hispanic Origin? (Sprif Yes, epecify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indien, White, etc. White
Maryland 21215-0020 d2 should be illed within 72 hours at th and Mental Hyglens. T is marked other than "natural", or traumatic event, the Medical Exam	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)	ing	16b. Kind of Busi	ness/Industry
D Parity III				/
ylan Mental Mental arked o	David R. Groft, JR  Lisa D.	Harbaug	h	
ary send N	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rura	al Route Number	, City or Town, S	tete, Zip Code)
			PA 172	
Battimore, Amili. Pages 1 at Apartment of Has Important: if Item Inty Injury or other	20a. Method of Disposition  1 \( \tilde{\mathbb{M}} \) Burial 2 \( \tilde{\mathbb{C}} \) Cremation 3 \( \tilde{\mathbb{M}} \) Removal from State  4 \( \tilde{\mathbb{D}} \) Donation 5 \( \tilde{\mathbb{C}} \) Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Fountaindale Union Cem.	/20	Liberty	ity or Town, State Township County, PA
Ball permit, Depart import any int	21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Gr	ove Fun	eral Hon	ne, Inc.
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.			Approximete Interval Between
Physician / /Medical Examiner	Due to (dr as a consequence of):	urie	S	Onset and Death
physicia the burn	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or es a consequence of):  d.			
deeth deeth deeth deeth	d:	23b. Did to	bacco use cent	ribute to the cause of death?
E XD		1 🗆 Y	es 218 No	Probably 4 Unknown
		24e. Wes e perform	n eutopsy med?	24b. Were autopsy findings available prior to completion of cause of death2.
yeicien: The lis certificate ha		1 1 1 Ye	es 2 No	1 Yes 2 No
VICEIN: The contilicate inector, par	25. Was case referred to medical examiner? 26. Place of Death	h (Check only on	(e)	
0 5 5 7			ence 6 Other	
SIOD O tending Ph leath. tor: Attenth the funeral	27. Manner of Death 28b. Time of Injury at Work? 1 Natural 5 Pending 28c. Accident investigation 28c. Injury at Work? 1 Year) 1 Year	Ped pot	Tan 5	fruck by motor
har de lin by	20 Suisite 6 Could not be	28f. Location (St City or Town	reet end Number	or Rural Route Number,
	29a. Certifier (Check only one)  29a. Certifying Physician: To the bast of my knowledge, death occurred at the time, date end place, (Check only one)  1 Certifying Physician: To the basts of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, one)			
within To the compli	250. Signature and title of certifier 29c. License number	2	9d. Date signed	(Month, Day, Year)
	Putane M.D. O.C.M.E.		May 18	, 1999
	30. Name and address of person who completed cause of death (flor 23a) (Type, Print)  10. Name and address of person who completed cause of death (flor 23a) (Type, Print)  111 Penn Street,	Baltim	ore, Mar	yland 21201
State	31. Date filed (Month Day Year) 32 Redistrar's Signature			
Registra	MAY 1 9 1999 B. Sparks			

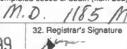


#### Please Type or Print in Black Indelibie Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** GAYLOR SUSAN ELIZABETH MAY 4:50 AM /Medical 4c. County of Death 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner Hagerstown Washington OFFMAN NURSING 40ME If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) Birthplaca (Steta or Foreign Country) **Funeral** 1 M 2 X F Months 184-09-3258 86 Director Dec. 27, 1912 Pennsylvania Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or liams 23a or 28a-f ahor the Medical Examiner must be notified at 15 Yes 2 No Director Washington Hagerstown Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 West Baltimore Street 21740 U.S.A. 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forcas? 14. Rece - American Indien, Bleck, Whita, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 Nevar Married 2 Married 1 ☐ Yes 2 ☑ No Specify: py 3 ₩ Widowed 4 Divorced White Year or Detes Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry should be filed within 7 and Mental Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) Personal Residence Homemaker 17. Fether's Nema (First, Middla, Last) 18. Mother's Neme (First Middle Maiden Sumame) Be 1 and 2 should be Health and Mental Susan Rockwell Riley P. Sipes 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) = 13922 Pennsylvania Ave. Hagerstown, Maryland 21742 Important: If item 27 any injury or other tr Saundra Myers/ Niece 20b. Plece of Disposition (Name of cemetery, cremetery or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Dete ō 1 Burlal 2 Cramation 3 Removel from Stete Department Rose Hill Cemetery May 17, 1999 4 ☐ Donetion 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signeture of Funaral Service Licensee 22. Name end Address of Fecility Douglas A. Fiery Funeral Home Joucla H. Frey 1331 Eastern Blvd. N. Hagerstown, Maryland 21742 tenter the mode of dying, such as cerdiec or respiretory arrest, Approximate 234. Part1. Enter the disease, or complications that caused the deeth. Do not enter shock, or heed reilure. List only one ceuse on aech line. **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) **Examiner** Examiner Sequentially list conditions, if eny, leading to immadiete cause. Enter Underlying Cause (Disease or Injury that initieted events rasulting in death) Last Due to (or es a consequence of): physician s the burial Physician/Medical Dua to (or es a consequence of): 8 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributs to the cause of death? been signed by the a should be detached 1 Yes 2€No 3 Probably 4 Unknown Q 24b. Wara autopsy findings available prior to completion of cause of death? Completed wff aewry 24e. Wes en eutopsy performed? 20 NO 1 ☐ Yes 2 ☐ No funeral director, 25. Was cese referred to medical examiner? 8 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Aversing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deal 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After 5 Pending investigation Division or Attanding 1 Maturel 1 Yes 2 No death. 2 Accident 24 hours after deat Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stefe) 3 Sulcide 28e. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide Hospital 1 Gertifying Physicien: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) end menner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) within 2 To the \$ 29b. Signature and title of certifier 29c. License number

State Registrar

te ar MAY 1 4 1999

DAMUEL



30 Name and eddress of person who completed ceuse of death (Item 23a) (Type, Print)

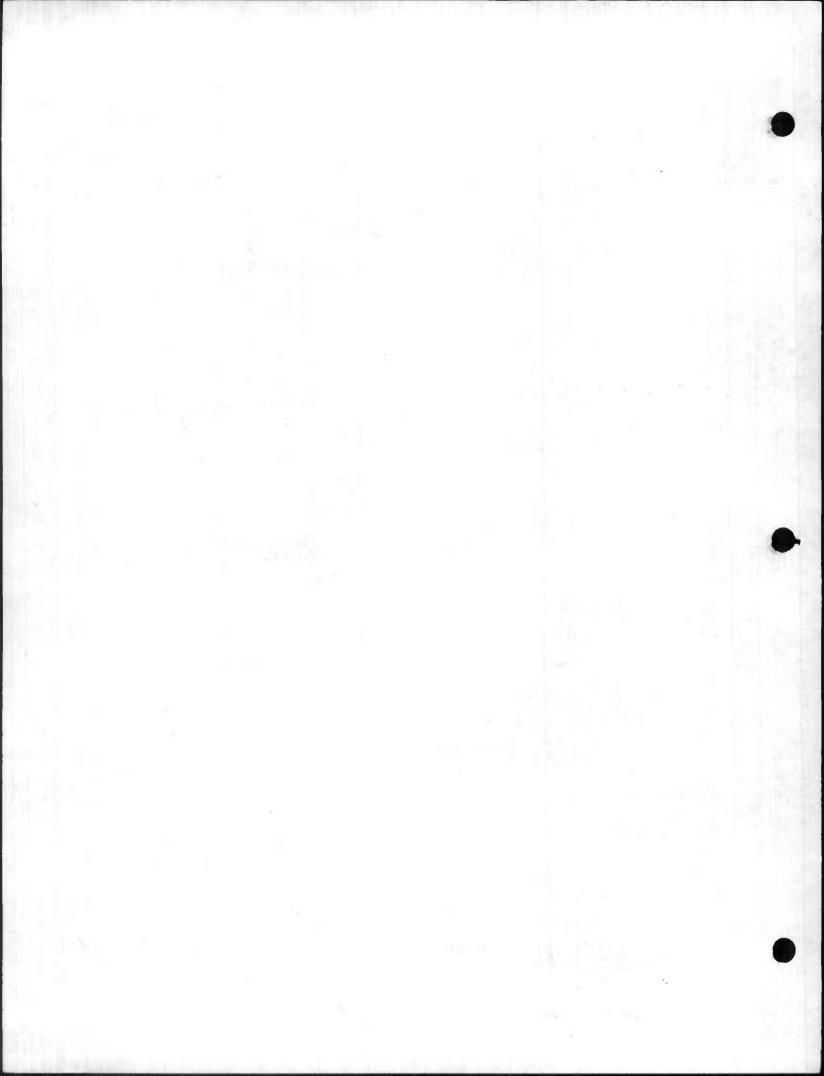
HAN

HAGERSTOU

29d. Deta signed (Month, Day, Year)

May 13, 1989

HAGERSTOWN, MD 2174



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Deeth 3. Time of Death

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Physician	ı
/Medical	Į
Examiner	I
Examiniei	ı
	п

**Funeral** 

Director Director Funeral

with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is merked other than "naturel", or itams 23e or 28e-f show any injury or other traumatic avent, the Mexical Exercises in cutted.

Baltimore, Maryland 21215-0020

**Physician** /Medical Examiner

The law requires that the death certificate be executed attending physician and for use as the bunal-transit P.O. Box 68760. ed by the a bengis d be del Records, s need should r this certificate has ral director, page 2 Division of Vital f or Attending Physician: after death. funeral After Director: / To the Hospital or within 24 hours aft To the Funeral Di completely filled in

1. Decedent's Nama (First, Middla, Last) Month A. GIBSON 9:03pm EMORY 1999 MAY 16 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street and number) Prince Georges Cheverly Prince Georges Hospital Center 8. Date of Birth (Month, Day, Year) If Undar 1 Yeer If Under 24 Hrs. 6. Sax 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months Hours 15 M 2□ F 213-56-5499 47 Aug. 4, 1951 Wash. Usual Rasidance of Decedant 10c. City, Town or Location 10d. Inside City Limits 10a. Stata 10b. County 1 Yes 2 No MD Pr. Geo. Laurel 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? U.S.A. 20707 617 8th Street 12. Was Dacedant Ever In U,S. Armed Forcas? 1 ☐ Yas 2 No If Yas, Giva Yaar or Datas: 14. Race - American Indian, Was Decedant of Hispanic Origin? (Spacify Yas or No-if Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 11 Marital Status Black, Whita, atc. 1X Nevar Married 2 Married Specify: Black 1 Yas 2 No Specify: by 3 Widowed 4 Divorced Completed 16a. Decedant's Usuel Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Spacify only highast grade complated) Buzzuto Corp Etamantary/Secondary (0-12) Collega (1-4or 5+) Technician 12th Housing Dev. Corp. 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumame) Be William F. Gibson Ellen Johnson 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code 20784 19a. Informent's Name/Ralationship (Type, Print) 6411 Fairbanks St., New Carrollton, MD George Gibson (Brother) 20b. Place of Disposition (Nama of 20e. Mathod of Disposition Data 20c. Location - City or Town, State cematary, cramatory or other place) 1 Buriel 2 ☐ Cramation 3 ☐ Ramovel from State Md. Nat'l Mem. Park 5/22/99 Laurel, MD 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name and Address of Facility
SNOWDEN FUNERAL HOME, 21. Signature of Funaral Service Lights in, or combilications that ceusad tha death. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, List only one causa on each line. Approximata Interval Batween Onsat and Death Immediata Causa (Final SEPSIS disease or condition resulting in death) Dua to (or as a consaquanca of): Examine ENCEPHALOPATH NONIC Sequentially list conditions, if any, laading to immediata causa. Enter Underlying Causa (Disaasa or injury that initiated evants rasulting in daath) Last Dua to (or as a consaquance of): Physician/Medical Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yee 2 No 3 Probably 4 Winknown PERICARDIAL 1 AMPONADE þ 24b. Wara autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed 1 Yas 2 No 1 Yas 2 No 25. Was cesa rafarrad to medicei axaminar? Be 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 10 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Magnar of Death 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: 28b. Tima of

1 Natural 5 Panding invastigation 2 Accident 3 Suicide 6 Could not be 4 - Homicida

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Spacify)

1 Yas 2 No

28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)

29b. Signatura and titla of certifier

Medical Examiner: On the best of my knowledga, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signad (Month, Day, Year) 29c. Licansa number

D0053733

30. Name end addrass of parson who complated ceusa of death (Itam 23a) (Type, Print)

SANJOV LAKHANPAL, M.D. 3001 HOSPITAL DR. CHEVERLY, MD. 20785

31. Data filad (Month, Day, Year)

MAY 21 1999

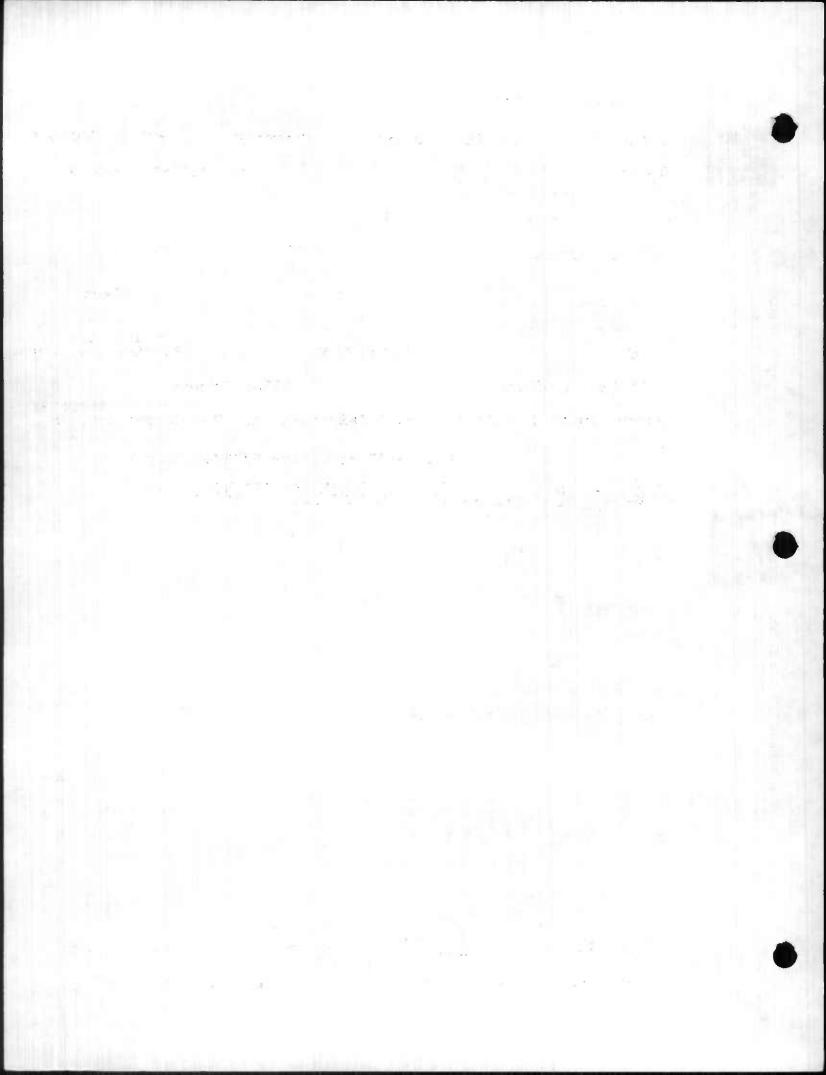


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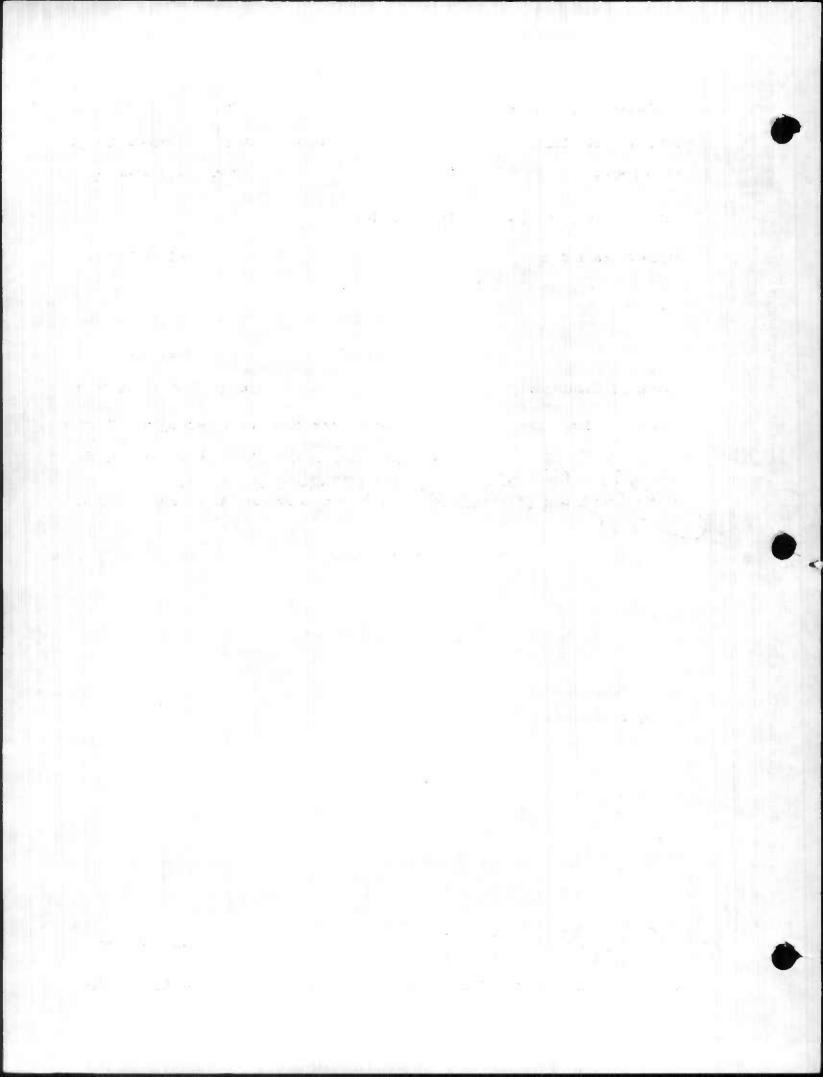
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State of Maryland / Department of Health and Mental Hygiene

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edical miner	4a Facility Nama				ber)			4b. City, Town	, or Location of De	ath 4c	. County	of Death		
	11506 Ca	rroll (	Court					Upper Ma	arlboro	P	rinc	e Geon	ges	
al or	5. Social Security I 577-86-9	301	6. Sex	21XF	7. Aga (In yrs 79	. last birthday) Yrs.	If Undar 1 Y Months D	aar If Under 24		Birth Day, Year)	920	9. Birthpla Country Pennsy	ce (State or v) vlvani	
	Usuel Residance of	of Decedant	v		100.0	ity. Town or Lo	cation						J. Insida City	
5	MD	Prince	•	rage		per Mar						100	1 🖾 Yas	
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by Funeral	11. Marital Stetus 1 □ Nevar Man 3 ☒ Widowad	ried 2 Mai	12.	Was Dace Armed For 1 Tas If Yas, Giv Yeer or Da	2 🔁 No	3		of Hispanic Origin Cuben, Maxicen, P	? (Specify Yes or Puerto Ricen, etc.)				Indian, c.	
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	21. Signature duf	Wa.	Licensee	E	16.1			ddress of Facility Funeral Orgia Ave				rton.	D.C. '	
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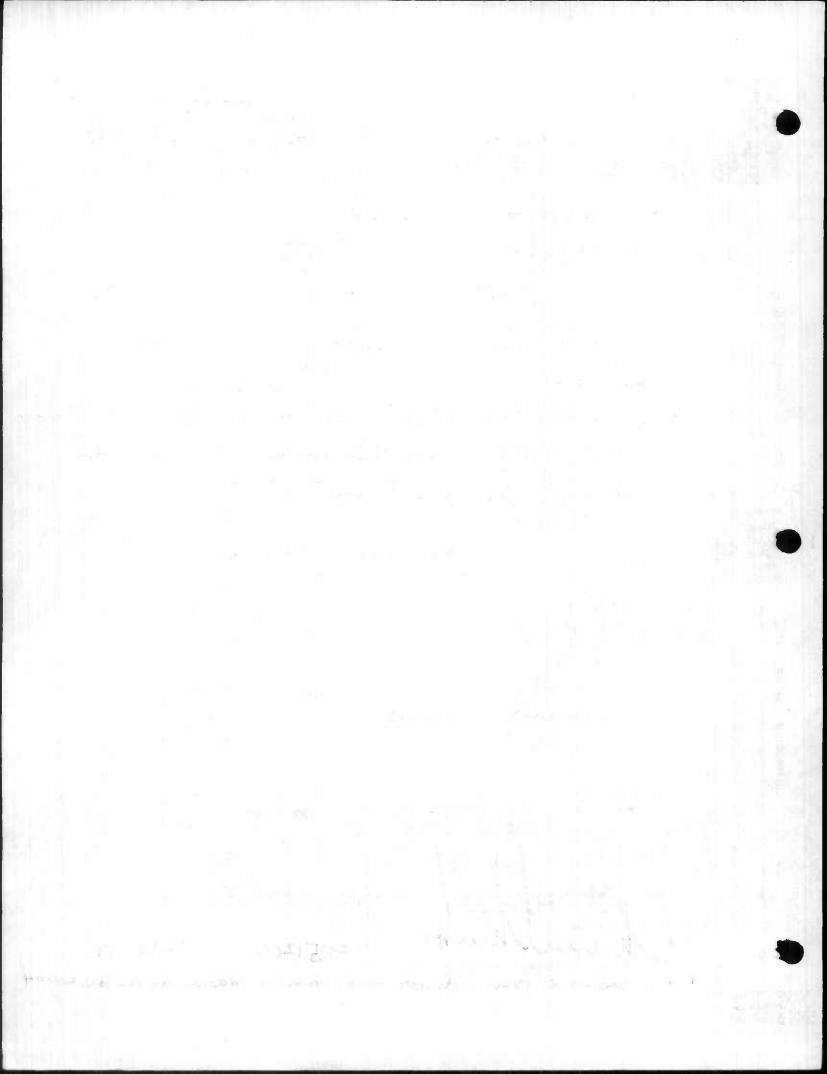
DHMH 16 Rev 6/95



State of Maryland / Depart

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					Cei	rtificate of	Death		Re	g. No.		
Physiciar /Medica	_	1. Decedant's Nama (First, Midd RUTH	dia, Last) M. GRAY						2. Data of Death Month MAY 15		9 <sup>Yaar</sup>	3. Tima of De 9:15
Examine	-	4a. Facility Nama (If not instituted  Manor Care						own, or Lo	ocation of Daath	4c. County MONT	of Death	ξĀ
Funeral Director		5. Social Sacurity Number  489-07-8684  Usual Rasidance of Dacedant	6. Sax 1 □ M XXF	7. Aga (In yrs. last I	Vrs.	If Under 1 Year Months Days		24 Hrs. Min.	8. Data of Birth (Month, Day Oct. 3	( <sup>Yaar)</sup> 191	9. Birthpla Country 0 P∈	ca (Stata or Fo
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r items 23s or 28s-f show ther rough be notified at Finners! Director	ai Dire	10e. Street and Number 22909 Davis	Mill Ro	ad		10f. Zip Coda	20876		10	g. Citizan of U	What Country	
and Examinet must be notified at the National Property of Standard at the National Actions of Property of Standard Inspector	2	11. Marital Status  1 □ Navar Marriad 2 □ Mai 3 ☑ Widowed 4 □ Divorce	rried Armad F	2⊠ No iiva	l II	Vas Decedant of f Yas, specify Cu I ☐ Yas 2X No	ban, Maxicar	n, Puarto	ecify Yas or No- Rican, atc.)	Bla	ce - Amaricar ck, Whita, at y: Whit	C.
Department of Health and Mentel Hygiene. Important: If Item 27 is merked other than "natural", or items any injury or other traumetic event, the Medical Examination once.  To Be Completed by Errore	ошріете	15. Deceda (Specify only highe Elementary/Secondary (0-12)	nt's Education ast grada complated Collaga	(1-4or 5+) Yrs.		lant's Usual Occu kind of work don OO NOT usa ratir USEWI£		it of worki	fing 1	6b. Kind of B	usinass/Indu	stry
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rector: After the by the funeral tification:		27. Mannar of Death  Natural  Accident  Suicida  Homicida	gation A		Tima of Injury	28c. Inju Wo M 1 [	iry at ork? ] Yas 2 ☐ I	No 2	28d. Dascribe how 28f. Location (Stre City or Town,	injury occur	red	Pouta Number,
within 24 hours aff To the Funeral Di completely filled in		29a. Certifler (Check only one) Sertifyin (Check only one)	evenueum: duting 6	best of my knowledges of examination a	a, death	occurred at the t	ima, data an opinion, deat	d place, a	and dua to the cau	sa(s) and ma e and place,	anner as state and due to th	ed. e cause(s)
To the comple		29b. Signature and title of certifie	1/ //	mus	)		sa number	20	- 11111111	5-10		y, Year)
		30. Name and address of person		- 11	(Type, F		5 12	-00			n-11	
	14	MOGNE HECK	200	11 BKE COS	- 1 a Pm	PARK.	7-00 C	-03	Cr Ever	1-1		11000

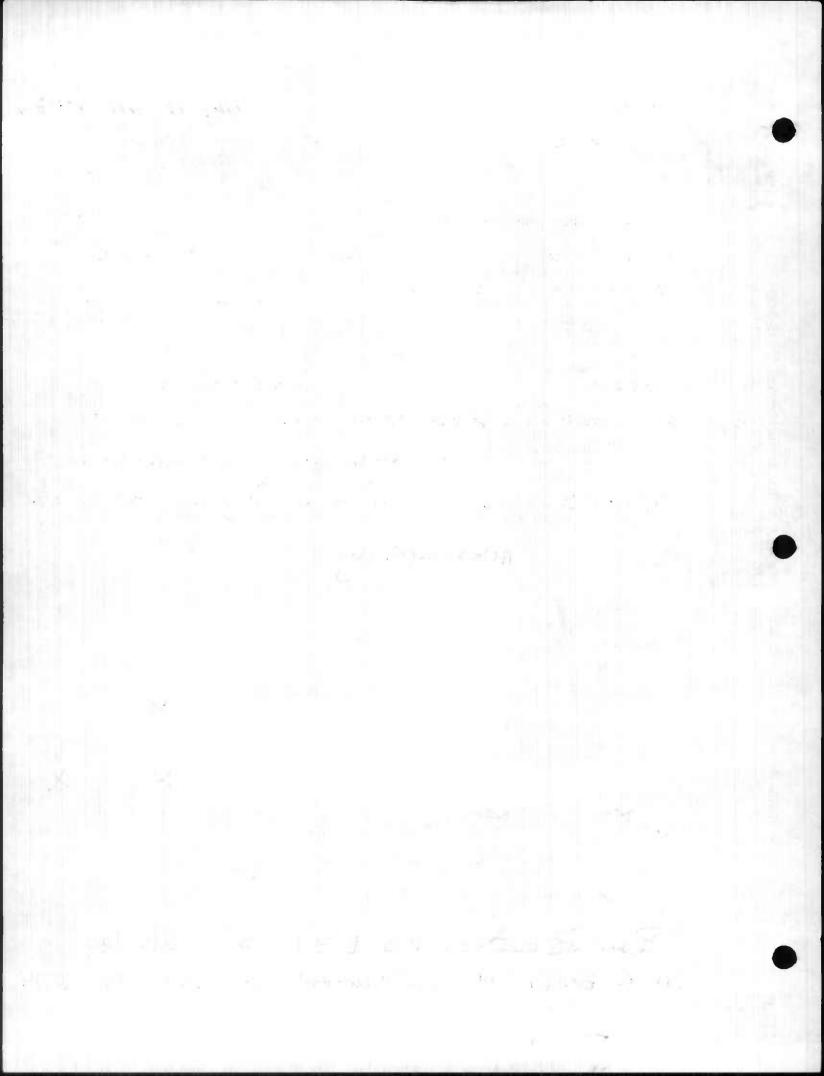


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth 10:30 **Physician** Viviana 1999 Gudiel MAY pm /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Silver Spring Holy Cross Hospital Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Devs Hours Min. (Month, Dev, Year) 5 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Deys Hours 30 19, 1999 Director May Maryland none Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a State 10h. County 10c. City. Town or Location 7 is marked other than "natural", or items 23a or 28a-f ahow treumstic event, the Mexical Examiner must be notified at 1 Ves 2 No Directo Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3504 Ellerton Road 20716 United States Funeral deeth 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14 Rece - American Indian 11. Maritai Stetus permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Health and Mental Hygiene. Important: if flem 27 is marked other than "natural", or iten any injury or other treumatic event, the Model Estimated. Biack, White, etc. 1 Never Married 2 Merried 1 No Specify: Baltimore, Maryland 21215-0020 Specify: White by Guatemalan 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nery Gudiel Lucrecia Betancourt 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Nery & Lucrecia Gudiel (parents) 3504 Ellerton Road, Bowie, Maryland 20b. Piece of Disposition (Neme of cemetery, crematory or other piece) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State 5-21-99 4 ☐ Donetion 5 ☐ Other (Specify) Chesapeake Crematory Beltsville, Maryland 22. Name and Address of Fecility
Rapp Funeral Services, P.A. 21. Signeture of Funerei Service Licensee 933 Gist Avenue, Silver Spring, Maryland a 20910 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth P.hysician /Medical tmmediete Ceuse (Final ANCHCED disease or condition resulting in death) Examiner Examiner physicien and s the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence of) thet the death certificate be execu Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es a consequence of) 98 esn ō signed by the a Pert il. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert i. 23b. Did tobacco use contribute to the cause of death? No 3 Probably 4 Unknown 1 Yes þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Was an autopsy performed? page 2 has No certificata 1 Yes Hospital or Attending Physicien: 24 hours after death. Funeral Director: After this certifica 25. Was cese referred to medical exeminer? director, Be 26. Plece of Deeth (Check only one) Hospitai: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Lo 1 Yes No funeral 27. Manner of Death 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred Certification: 5 Pending investigation Netural Injury 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) in by 4 ☐ Homicide 24 hours edical To the Hospi within 24 hou To the Fune completely fil 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and menner stated. (Check only one) 29b Signatore and title of certific 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

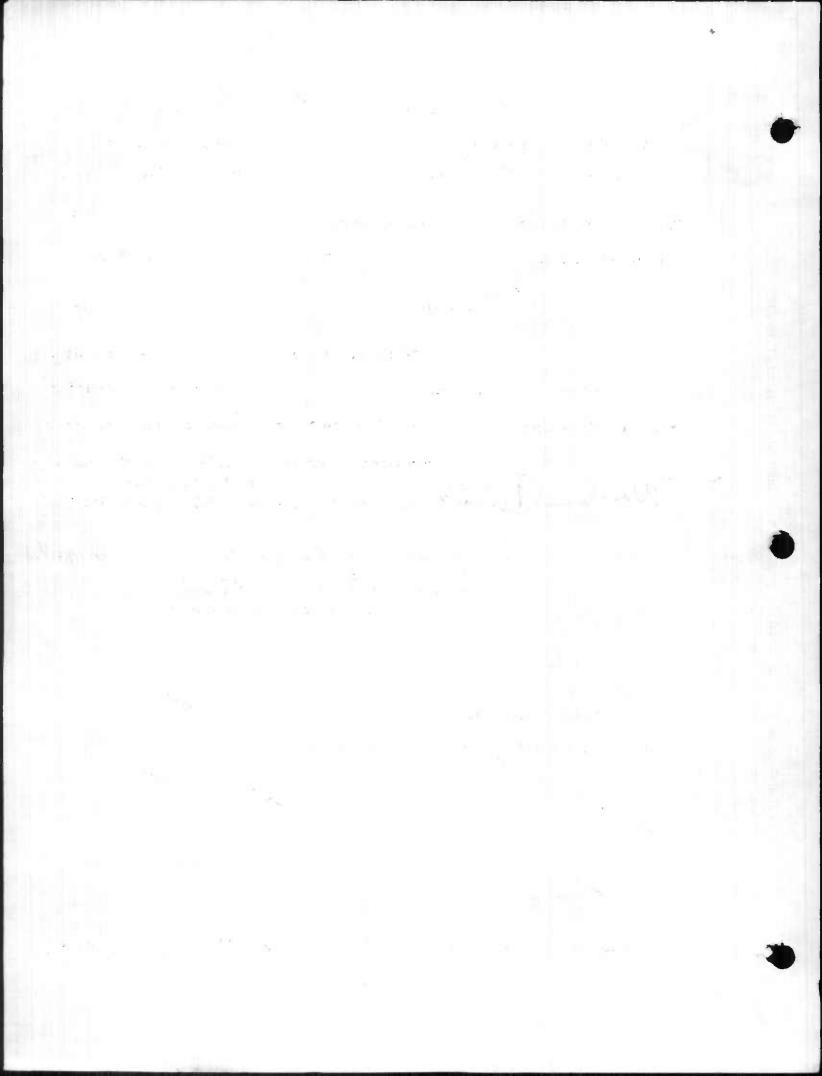
BPUCF BOLLON MD 1221 No Bolten Cargo Mercantile 1221 31. Date filed (Month, Day, Year) 32. Registrer's Signature State MAY 21 1999

Registrar



	1. Decedent's Name (First, Middle, Last)	e of Death	Reg. No. Deeth 3. Time of Deeth
Physician		Month	Dey Year
/Medical	Margaret E. Guggenheimer  4e Fecility Neme (If not institution, give street end number)	4b. City, Town, or Location of De	19, 1999 1:00 PM eth 4c. County of Deeth
• Examiner	Wind Total College Col		25 1-003 EXEMPLE
	Wilson Health Care Center  5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1	Gaithersburg	
Funeral Director	125-22-5766 1 M 2X F 82 Yrs. Months	Devs Hours Min /Month.	3irth Day, Year) 24, 1916  9. Birthplece (State or Foreign Country) New York
pus &	Usuel Residence of Decedent  10a. Stete 10b. County 10c. City, Town or Location		10d, inside City Limits
dany dany	Manual and Mantagement Codthough		1⊠ Yes 2 □ No
or 28a-f s	Maryland Montgomery Gaithersbu		10g. Citizen of Whet Country?
A Sa or		20877	United States
fter death v r items 23 iner must	11. Meritel Status 12. Wes Decedent Ever in U.S. 13. Wes Decede	ent of Hispenic Origin? (Specify Yes or fy Cuben, Mexican, Puerto Rican, etc.)	
by by	3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Detes: 1 Q / 3 / 1 Q / 7		Bleck, White, etc.  Specify:  White
72 hours natural;	15. Decedent's Education 16e. Decedent's Usual	Occupetion	16b. Kind of Business/Industry
	(Specify only highest grade completed) (Give kind of work life. DO NOT use	done during most of working a retired)	
W 5, 0 "1, ()	12 Office Su		Federal Government
in yearlo a should be filed ad Mentel Hygied marked other imetic event, To Be Co	17. Fether's Neme (First, Middle, Last)	18. Mother's Name (First, Midd	fle, Maiden Surname)
2 should be and Mentel is marked o sumatic even	Matthew Futerer	Cathe	rine Fitzpatrick
2 2 2 2		(Street and Number or Rural Route Num	nber, City or Town, State, Zip Code)
C T M N			oke Pines, FL. 33028
0 8057	20e. Method of Disposition 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Removei Irom Stete	e of Date ner place)	20c. Location - City or Town, Stete
antimore, mit. Pages 1 er partment of Hee portant: if item;	4 Donetion 5 Other (Specify) Metropolitan Cr	rematory 5/21/99	Alexandria, Virginia
mmit. Page partment poortant: if ny injury o		Address of Encility	ineral Home
n agess	Much Wylha 10 Fort		
	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode	of dying, such es cerdiec or respiretory	ithersburg, MD. 20877 errest, Approximete
Physician	shock, or heert feliure. List only one ceuse on each line.		Interval Between Onset end Death
/Medical	Immediate Ceuse (Finel	10.1.10	2 000/61
Examiner	disease or condition resulting in deeth)	Harlule	0 /Y/01 14 15
je literatura	Due to (or as a consequence of	tructer	1
executed in and haltransit Examiner	Consection list conditions	security	
Exa	Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury	nacy desc	kee
icate be executed physician and s the bunal-transit edical Examir	that initieted events		
	resulting in death) Lest		
eath certification attending	d		
at the death certified by the attending etached for use a Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying ca-	use given in Part 1 22h Di	d tobacco. we contribute to the cause of death?
es that the de igned by the s be deteched by Physic	And the second s		Tes 2 No 3 Probably 4 Unknown
E 2 70	Journa		22 NO OD 1100EMY 10 OHRHOWN
VITAL MECONDS, slcien: The law requires to certificate hes been signe frector, page 2 should be D Be Completed by	Inemia 7 chronice		24b. Were autopsy findings
The law require tate hes been sit page 2 should b.	menu jarnu	actacio	eveileble prior to completion of cause of death?
The law ate hes b page 2 s	,		
Ficate Fr. Pa			7 Yes 247No 1 □ Yes 2 □ No
Physician: The Physician: The rithis certificate and director, page TO Be CO	25. Was case referred to medical examiner? 1  Yes 2	26. Place of Death (Check on)	
- 4 SP -	1   Yes 2   1   1   Inpetient 2   ER/Outpatient 3   DO/ 27. Mannpro Death 28a. Date of Injury 28b. Time of 28	4LI Nursing Home 5LI He	sidence 5 ☐Other (Specify) e how injury occurred
After fune	1 ⊠Natural 5 ☐ Pending (Month, Day Year) Injury	c. Injury at 28d. Describ Work? 1 ☐ Yes. 2 ☐ No	
DIVISION (b) or Attending P as effer death.  In Director: Attented in by the funers  Certification:	3 Suicide 6 Could not be 28e Place of Injury - At home, farm, street, factory	TOWNS COMMISSION	(Street and Number or Rural Floute Number,
Pring Pring	4 Homicide determined 200. Place of trijury - At norms, farm, street, factory, building, etc. (Specify)		own, State)
To the Hospital or Attending Physician 2 from site death. To the Funeral Director: After the Completely filled in by the funeral Medical Certification:	29e. Certifier 12 Cartifying Physician: To the best of my knowledge, deeth occurred et	t the time, date end plece, end due to the	ne cause(s) and menner as stated.
he Hospi in 24 hou he Funer pletely fill edical	(Check only one)  2 Medical Examinar: On the basis of examination and/or investigation, i end menner steled.		
Me of the		License number	29d. Date signed (Month, Day, Year)
	161Pelesta	11 14/15	M111191999
D	and the second of the	01115	ivay "
	30. Name end address of person who completed ceuse of deeth (Item 23a) (Type, Priot)		
	H. Robert Birschbach, M.D., 6320 Democracy  31. Dete filed (Month, Day, Year)  32. Registrer's Signature	Blvd., Bethesda,	MD. 20817
State Registrar	MAY 2.1 1999 B. Apa	uls	

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 

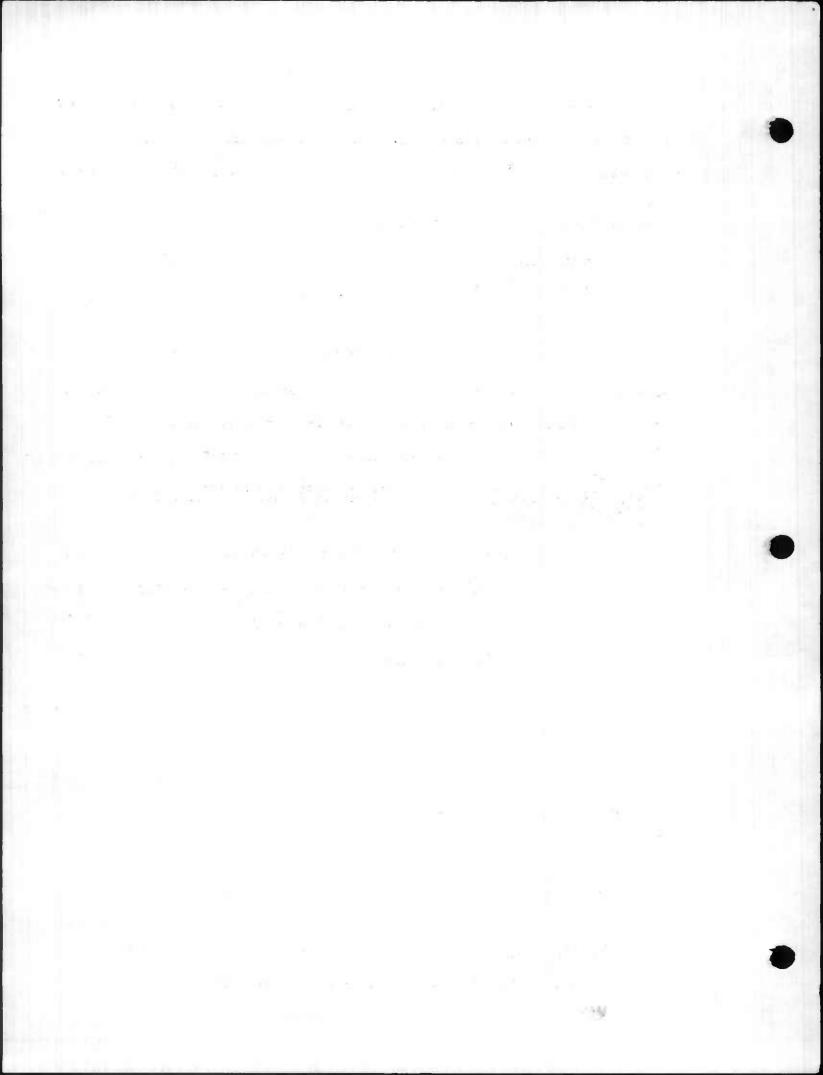
O Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Death 3. Time of Death Month **Physician** Goldsboro May 11 1999 0624 Joyce Ann /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner The Kent and Queen Anne's Hospital, Inc. Chestertown Kent 9. Birthpiace (State or Foreign Country) New Jersey 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 M 2 X F Days Hours Min Feb. 25, 1942 Director 57 216-38-9960 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10e Stete 10b. County 10d. inside City Limits 7 is marked other than "natural", or Itama 23s or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death Funeral Rosevelt Drive 21620 USA 303 12. Was Decedent Ever in U,S.
Armed Forces?

1 ☐ Yes 2 M No
If Yes, Give
Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Black, White, etc. Peges 1 and 2 should be filed within 72 hours effer or nent of Health and Mental Hygiene. nt: If Nem 27 is marked other than "natural", or her 1 ☐ Never Married 2 🕱 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify Specify þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education Elementery/Secondary (0-12) College (1-4or 5+) Line Worker Vital Food 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Brown Raymond Cotton Bertha 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) 303 Rosevelt Dr., Chestertown, Maryland 21620 Robert E. Goldsboro (husband) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department of important: If any injury or injury or 5/15/99 Mt. Zion Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Still Pond, Maryland neuer Service Lieensee 22. Name end Address of Facility Bennie Smith funeral Home P.O.Box 1687, Easton, Maryland 21601 Gruce in the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, heart failure. List only one cause on each line. Approximata Intervel Between Onset end Death **Physician** /Medicai alteroscleratic heart disease Immediate Cause (Final diseese or condition resulting in deeth) Examiner Examiner Heam Evol stak reval dereau sician and burial-transit that the death certificate be executed Sequentially iist conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) year Due to (or as a consequence of): arrenice Records, P.O. Box 68760, physician Physician/Medicai the Hears 40 60 My per Fewner USe 23b. Did tobacco use contributs to the cause of death? Part Ii. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. been signed by the should be detached 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown þ 24b. Wera autopsy findings aveitable prior to completion of cause of death? 24a. Was an autopsy performed? Completed hes page 2 25 No 1 TYes 2 No 1 Ves certificate Division of Vital Hospital or Attending Physician: 25. Was cese referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 940 this funeral 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28c. fnjury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Affer 1 Naturai 5 Pending after death. investigation 1 ☐ Yes 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end piece, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) end manner stated. 29a. Certifier Medicai (Check only one) To the Vithin 2 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 5/12/99 D 0046020 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Syed Ali, M.D., 506 Idlewild Ave., Easton, Maryland 21601

State Registrar 31. Date filed (Month, Dey, Year)

32. Registrat's Signature



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 7:36 P.M hyllis House 1999 May tenth 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore | Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) Baltimore Cit Maryland niversit Center Medica V OI if Under 1 Yea 9. Birthplace (State of Foreign 5. Social Security Number 7. Age (In yrs. lest birthdey) 1 M 2 F Months Days Hours 64 JUNE 8, MARYLAND 578-44-9421 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location 10b. County 1X Yes 2 No BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 601 SOUTH CHARLES 21230 USA STREET 14. Raca - American Indian, Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 11. Maritai Status 12. Was Decedant Evar in U,S. Armed Forces? 1 Yes 2 No If Yas, Give Year or Dates: Black, White, etc. 1X Never Married 2 Married WHITE 1 Yes 2X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation 16b. Kind of Business/Industry 15. Decedant's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grede completed) Elementary/Secondary (0-12) Collaga (1-4or 5+) PARTS ASSEMBLER MANUFACTURING 17 Fathar's Nama (First Middle Last) 18. Mother's Name (First, Middle, Malden Sumeme) LAVERNA E. BARNES NORMAN M. HOUSE 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Ralationship (Type, Print) 706 MIDLAND RD. COLESVILLE, MD 20904 LAWRENCE HOUSE (BROTHER) 20b. Placa of Disposition (Nema of cematary, cremetory or other in 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State 5-13-99 BRENTWOOD, MARYLAND FT. LINCOLN CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenser 22. Name and Address of Facility HINES-RINALDI 11800 NEW HAMPSHIRE AVENUE SILVER SPRING, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Intarval Batween Onset and Death Immediate Causa (Final disease or condition resulting in death) emic. 00 Saquentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or Injury that initiated avants resulting in death) Last Dua to (or as a consequance of): Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Vascular eriphera 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yas 2 No 1 ☐ Yes 2 No 26. Place of Death (Check only one) Hospital: Othar: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Dey Year) 28c. injury at Work? 28b. Time of 28d. Dascribe how injury occurred 5 Panding investigation 1 Natural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be

attending physician and for use as the bunal-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, signed by the a s cartificate has b Hospital or Attanding Physician: 24 hours aftar death. Funeral Director: After this cartifica stely filled in by the funeral director,

Physician /Medical

Examine

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Completed

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Certification: To

Medical

12

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene. Improfrant: If item 271s marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, in Marical Examiner must be notified an once.

Baltimore, Maryland 21215-0020

25. Was case raferred to medical 1 Yes 2 No

27. Mannar of Death

4 ☐ Homicide

29a, Certifian

28e. Piaca of Injury - At home, farm, street, factory, office building, etc. (Specify) Maching Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to tha cause(s) and manner as stated.

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29b. Signature and title of certifier

29c. License number

gruland

29d. Date signed (Month, Dey, Year) tenth, 1999

Green-Street

30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

hitta University 31. Data filed (Month, Dey, Year) MAY 1 7

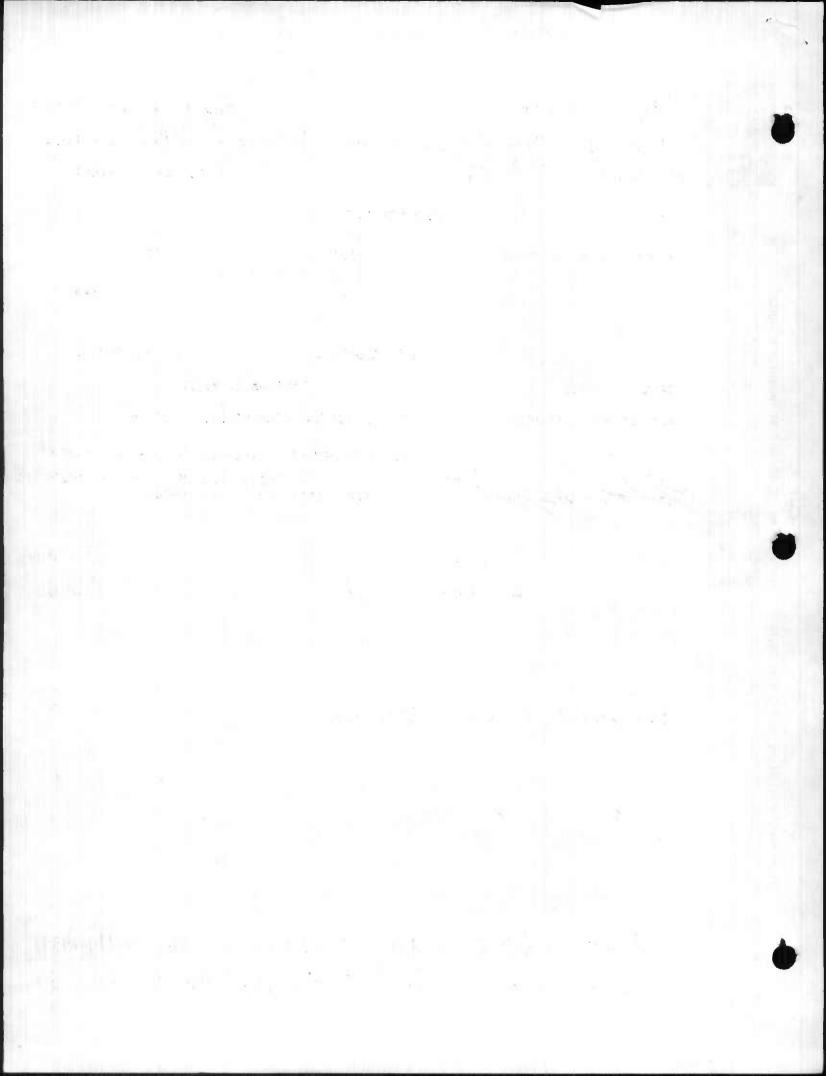
1999

32. Registrar's Signature Ruce

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

To the Hospital or within 24 hours aft To the Funeral DI completely filled in



Please Type or Print in Biack indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month **Physician** GAIL ELIZA HUNTER May /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Facility Name (If not institution, give street and number) Examiner Hagerstown W.
If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Washington County Hospital Washington 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days 1 M 20X 52 Yrs. 174-38-7787 JUN 1,1946 Pittsburg, PA Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f show 1 ☐ Yes 2 ☐ No MD Washington Smithsburg Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ? is marked other than "natural", or items 23s or traumatic syant, the Medical Examiner must be 23130 Welty Church RD 21783 USA death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of or chall and Mentel Hygiene.
Int: if item 27 is marked other than "natural", or item into or other traumatic svent, "as lead as I marked on item or or other traumatic svent, "as lead as I manning. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0020 1 Ves 2 X No Specify: p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elemantary/Secondary (0-12) College (1-4or 5+) 4 Real Estate Agent Real Estate Sales 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) James Blaine Byers Dorothy Boyce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) 23130 Welty Church Rd Smithsburg MD 21783 Samuel C. Hunter 20b. Place of Disposition (Name of cemetery, crematory or other placa) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If It any Injury or o 1 ☐ Burial 2 ☑ Cremation 3 ☒ Removal from State Omberland Valley Crematorium May 18 Waynesboro PA 17268 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Grove Funeral Home, Inc. 21. Signature of Funeral Service Licenses 50 S Broad ST Waynesboro PA 17268 Docuersay runes) (T. 23a Pairl. Enter the disease, or complications that of used the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final diseasa or condition resulting In death) . breast cancer metastatic to the brain two years Examiner Dua to (or as a consequence of): Physician/Medical Examiner law requires that the deeth certificate be executed physician and s the burial-transit Sequentially list conditions, if any, leading to immediate causa. Entar Undarlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): Due to (or as a consequenca of): signed by the a d be detached f 23b. Did tobacco use contribute to the ceuse of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, P. þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy nis certificate hes b i director, page 2 s 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attanding Physicism: 25. Was casa rafarrad to medical examiner? Be 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To this funerai 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 1 Datural 5 Panding To the Hospital or Attandir within 24 hours after death. To the Funeral Director: At completaly filled in by the fu deeth. 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicida 29a. Certifiar (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture end title of cartifier May 15, 1999 Oynthia Kuttner - Sands no

11110 Medical Campus Road Hagerstown, 2174

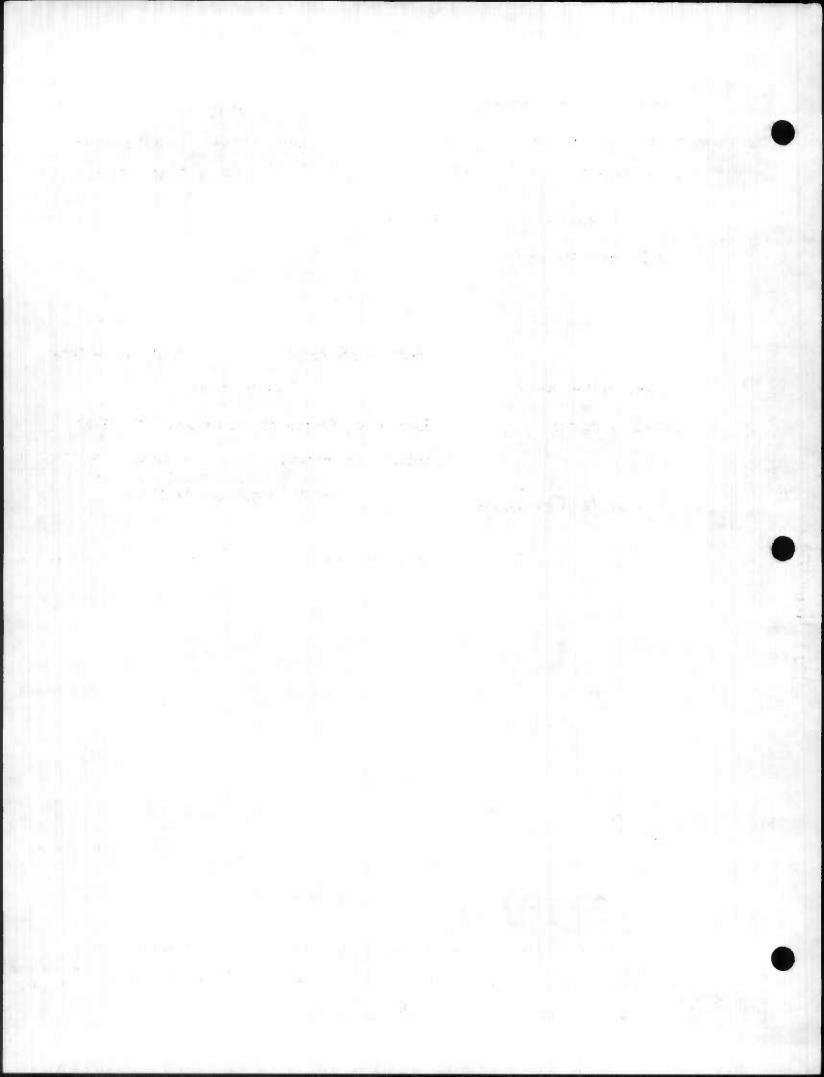
State Registrar 30. Name and address of person who complated causa of death (Item 23a) (Type, Print)

32. Registrar's Signature

Cynthia Kuttner-Sands, mo

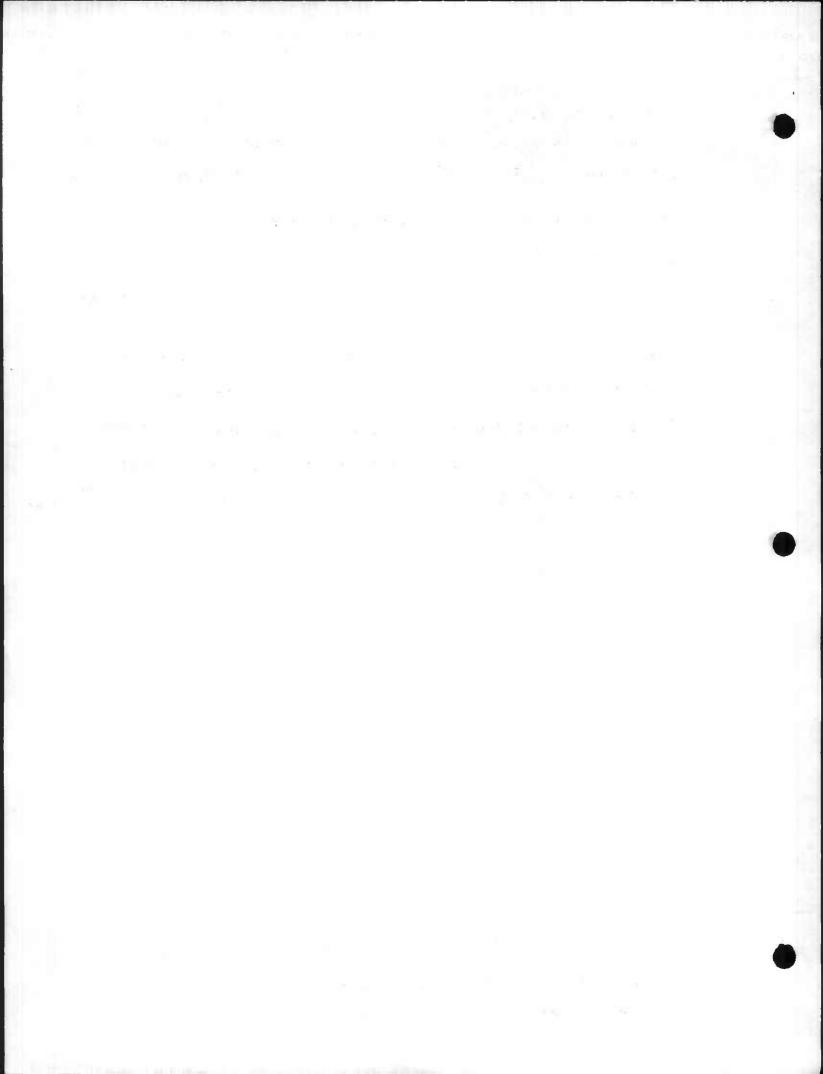
MAY 1 9 1999

31. Date filed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene

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		Physici /Media		Nett	ie Hug	hes							May	12,	1999	1 (	)405
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						ounty H	-						own, Mo		hing		
	1	Funeral Director		5. Social Security N 215 20	8688	. Sex 1 □ M 2 1 F	7. Aga (In yrs. 7.		Months	Days	If Undar Hours	24 Hrs. Min.	8. Deta of Bir (Month, Da 1 / 18)	th ly, Year) 125	9. Birthp Coun		tate or Foreign
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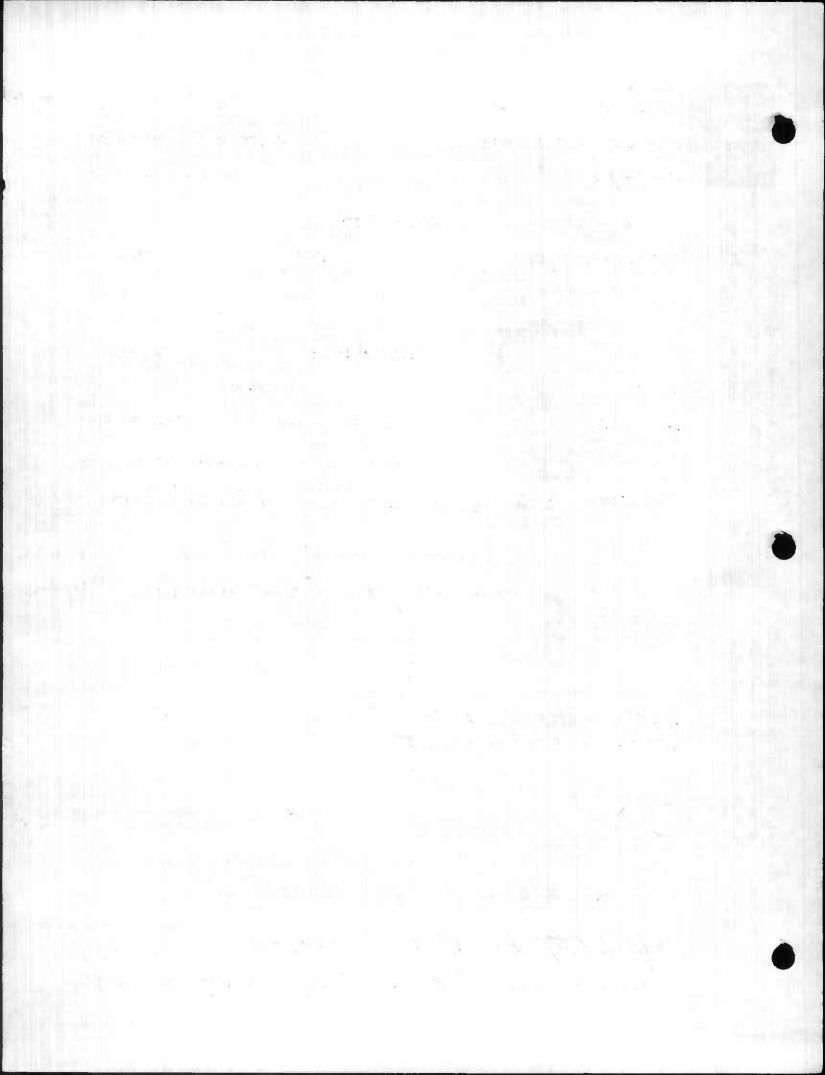
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) 10 Aug **Physician** ZE HS14N9-/Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner SILVER SPRING MONTGOMERY MANOR CARE OF SILVER SPRING If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** Days 1∭ M 2□ F Yrs. 84 CHINA Director 219-29-9090 JAN 29, 1915 Usual Residence of Decedent the Meryland 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Directo SILVER SPRING MARYLAND MONTGOMERY 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? with permit. Pages 1 and 2 should be filed within 72 hours efter death w Department of Health and Mental Hyglens.
Important: If item 27 is marked other than "naturel", or head any njury or other treumatic svent. 20905 CHINA 15700 EVESHAM PLACE Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Maritel Stetus 1 Yes 2 No It Yes, Give Year or Dates: 1 Never Married 2 Married Specify: ASIAN 1 Yes 2 No Specify: by 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16h Kind at Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) RAILROAD CIVIL ENGINEER 4 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) F.C. CHANG S.H. LO 19e. Intorment's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15700 EVESHAM PLACE SILVER SPRING, MD 20905 DAVID LO/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method ot Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 05/24/99 BRENTWOOD, MD LINCOLN CREMATORY 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility HINES-RINALDI FUNERAL HOME, INC. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. 11800 NEW HAMPSHIRE AVE SILVER SPRING, MD 20904 Approximate Interval Between Onset and Death **Physiclan** /Medical Immediate Cause (Final disease or condition resulting in deeth) month Examiner Examiner end I-transit The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last physicien e s the buriel-1 P.O. Box 68760. Physician/Medicai Due to (or as a consequence ot): 98 HSB HSB ō Part It, Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? ed by the datached 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificata has t 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No or Attending Physician: director, 25. Was case reterred to medical examiner?

1 Yes 2 No Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Menger of Deeth 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: completaly filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and manner as stated.

Medical Examiner: On the best of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the I 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 13550 Bernalette Soong H.D 30. Name and address of person who completed cause of deal (Item 23e) (Type, Print) 31. Date filed (Month, Dey, Year) 32. Registrar's Signature

State Registrar

MAY 21 1999



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month 3. Time of Death Year CHIN MENG HSIAO MAY 14, 1999 11:45 P.M. 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth

Examiner

**Physician** 

/Medical

Funeral Director

Nems 23s or 28s-f show

Baltimore, Maryland 21215-0020

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 64 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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256-19-8106	ex 7. Age ☐ M 2□XEX	(In yrs. last b	Yrs. If Unde Months	r 1 Year Days	If Under 24 Hours I	Vin. (Mon	of Birth th, Day, Yea 19,			State or Foreign
Usuel Residence of Decedent										
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MARYLAND   MONTGOME	SKY	SILVER	SPRING							
10s. Street and Number			10f. Zip	p Code			10g. C	Citizen of \	What Country?	
1412 BILLMAN LANE			20	902			IINT	TED S	TATES	
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1 Never Married 2 Merried	Armed Forces? 1 ☐ Yes 20XN		If Yes, spe	city Cuba	n, Mexican, P	uerto Rican, el	(C.)	Bied	ck, White, etc.	
	If Yes, Give	9	1 Yes	MXNo	Specify:			Specify	<i>r</i> :	
3\0X\Widowed 4 □ Divorced	Year or Dates:								CHINE	SE
15. Decedent's Ed (Specify only highest gra		16	<ul> <li>Decedent's Usu (Give kind of wo</li> </ul>	al Occup	ation	unding	16b.	Kind of B	usiness/Industry	
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17. Father's Name (First, Middle, Last)			HOODEWII		10 Mothor's	Name (First, A			ial	
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19e. Informent's Neme/Reletionship (1	Type, Print)	19	b. Meiting Address	s (Street	and Number o	r Rural Route	Number, City	or Town,	Stete, Zip Code	
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20a. Method of Disposition	TEL -SOM		of Disposition (Na		ANE, S.	Date		-	City or Town, S	ete
20a. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐	Removel from State	cemet	ery, crematory or	other plac	e)	Date	200.	Location -	ony or rown, S	0.0
4 Donetion 5 Other (Specify		GATE	OF HEAVE	N CE	METERY	5-22-	99 STI	VER	SPRING	MARYLA
21. Signature of Funeral Service Licen	1500/	, 0.1111	22. Name a	_		12 22	J J L U L I	O TOTAL	OF ILTHOS	THE LANGE
0/10	de					NERAL H	OME.	INC.		
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239 Fert1. Enter the disease, or comp shock, or heart feilure. List only	plications thet caused	ne death. Do	not enter the mor	de of dyin	g, such es ce	rdiac or resptre	tory arrest,		Appr	oximete el Between
shock, of heart lendre. List only	One cause on each link	в.							Onse	t end Deeth
Immediate Cause (Finel										
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resulting in deeth)	[	Due to (or as a	consequence of)	:						
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resulting in death) Last	d				en in Pert I.	231				
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resulting in death) Last	d				en in Pert I.			2□ No	3 Probably  24b. Were au aveilable	4 ☑ Unknow topsy findings prior to
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DHMH 16 Rev 6/95

State

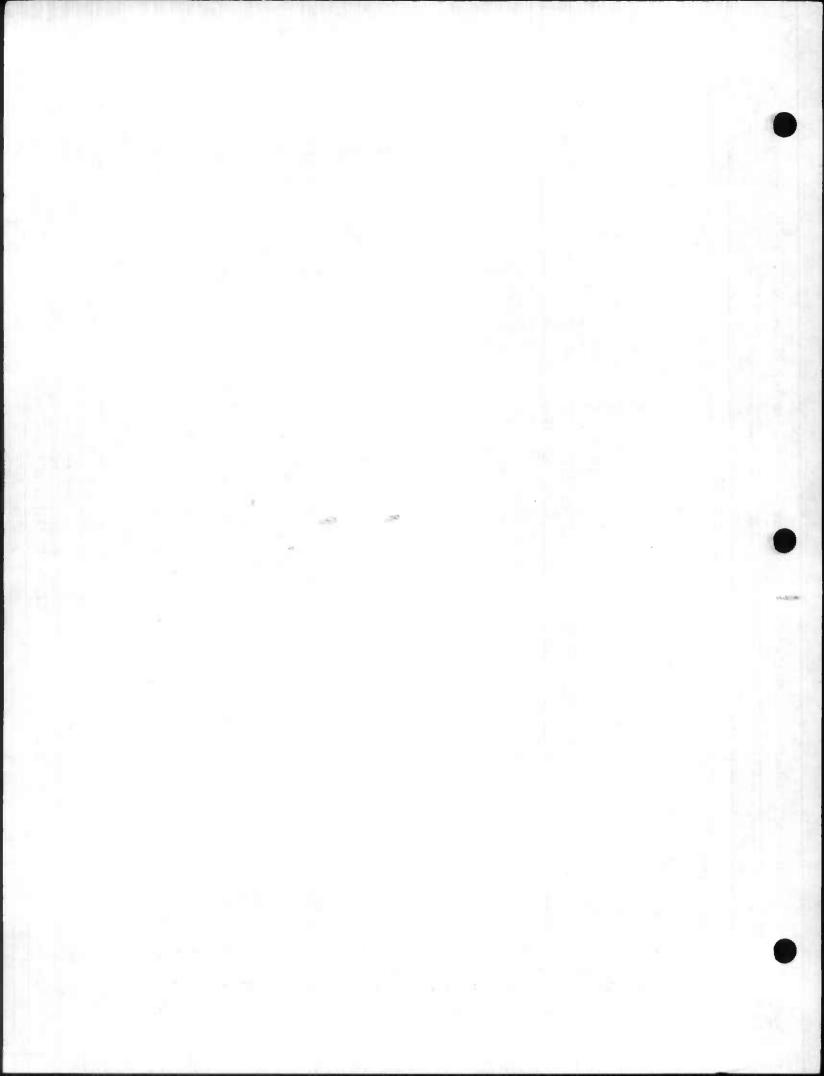
Registrar

R. SHUMACKER, M.D.,

MAY 19 1999

31. Date filed (Month, Dey, Year)

2309 SHOREFIELD ROAD, WHEATON, MARYLAND 20902

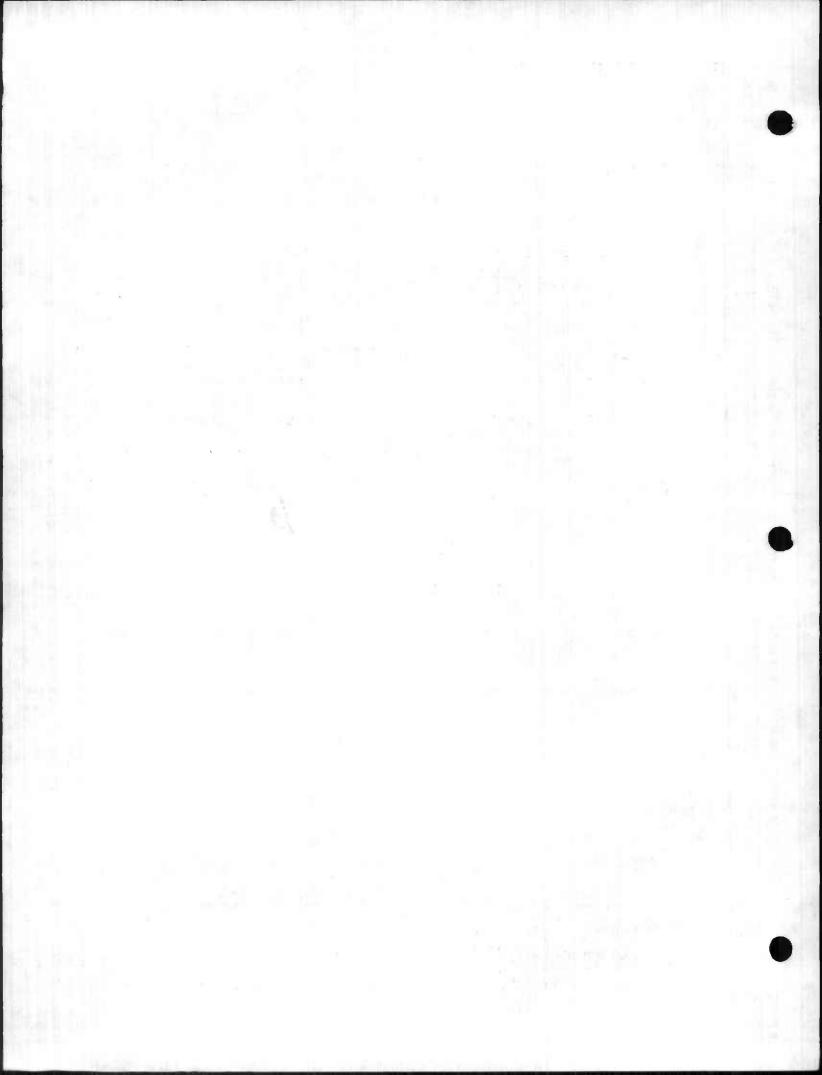


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eral ctor	5. Social Security 217-42	-3094	Sex 1MM 2□F	7. Age (In yrs. 5 4	last birthday Yrs.	Months Days		8. Date of Bi (Month, D Mar.	oth av. Year) 31,194!	9. Birthpli Count Max	ace (State or Foreign ry) Cyland	
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be notified Director	10e. Street and N					10f. Zip Code			10g. Citizen of	What Count	try?	
	506	9th Stre	eet		- A	2	20707		U.S	5.A.		
by Funeral	1	rried 2 Married	12. Wes Dece Armed For Valves If Yes, Give Year or Da	ces? 2 🗆 No	I,S. 13.	Wes Decedent of If Yes, specify Cu	Hispanic Origin? (sban, Mexican, Pue	Specify Yes or Norto Rican, etc.)		ce - America ck, White, e y: Bla	etc.	
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8	21. Signatura of F	Funeral Service Lice	ensed /		1 2	2. Neme end Add		77 11016				
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State Registrar 31. Date filed (Month, Day, Year)
MAY 1 9 1999

32. Registrer's Signeture

or's Signeture B. Sparks



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Des Month Year **Physician** MAY 13, 1999 ROBERT L. HEINBAUGH 7:51PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD COUNTY GENERAL HOSPITAL HOWARD COLUMBIA 8. Date of Birth (Month, Day, Year) JAN 27, 1923 PENNSYLVANIA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthpleca (State or Foreign Days Months Hours 10 M 2□ F Yrs. 76 577-24-9423 Usual Residence of Deceden 10a. Stete 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Director SILVER SPRING MARYLAND MONTGOMERY 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1510 CRESTLINE ROAD 20904 UNITED STATES Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ऄ Yes 2 □ No If Yes, Give 14. Rece - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: WHITE 1 Yes 2 No Specify: p 3 ☐ Widowed 4 ☐ Divorced Year or Detes: 1944-45 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) INVESTIGATOR US GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LOIS LILLIAN STIFFLER CHARLES E. HEINBAUGH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6557 RIVER RUN COLUMBIA, MD 21044 NANCY CUMMINS/DAUGHTER 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/17/99 BRENTWOOD, MD LINCOLN CEMETERY 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility
HINES RINALDI FUNERAL HOME, INC. Willy 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. 11800 NEW HAMPSHIRE AVE SILVER SPRING, MD 20904 Approximate tnterval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) PULMONARY EMBOLIS Due to (or as a consequence of) Examiner SEDENTARY POST OPERATIVE STATE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): MENINGIOMA SURGERY Physician/Medical Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Was en autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 🛱 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Naturat 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and MAY 14, 1999 D24886 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10801 LOCKWOOD DRIVE SUITE 280 SILVER SPRING, MD 20901 EIG, MD MARK H.

To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun

State Registrar

**Funeral** 

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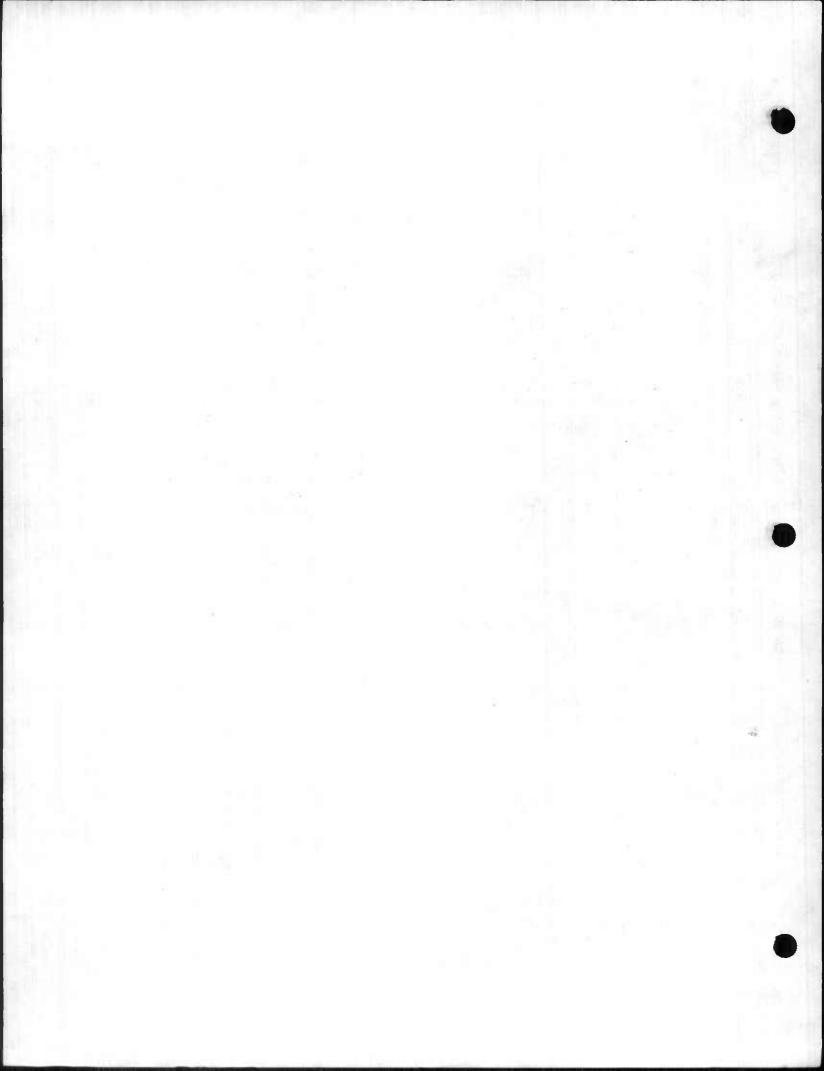
filed within 72 hours after

21215-0020

Baltimore, Maryland

31. Date filed (Month, Day, Year) 17 1999 MAY

32. Registrer's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death 3. Tima of Death 1. Decedent's Nama (First, Middla, Last) Month Dav **Physician** 90 an 5 Mar /Medical 4a Facility Name (If not institution, giva street and number), 4b. City, Town, or Location of Death 4c. County of Death Examiner 05 9 VE 0000006 8 Data of Birth (Month, Day, Year) If Under 1 Yaar If Undar 24 Hrs. 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foraign **Funeral** Days Months Hours 10XM 20 F Director 215-36-5199 60 JAN. 29,1939 WASHINGTON, D.C Usual Rasidance of Decedant 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits ehow. r than "natured", or flems 23s or 28s-f show the Heal rail Examiner must be notified at 1 ☐ Yas 2 ☑ No Director MONTGOMERY SILVER SPRING 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 739 SILVER SPRING AVENUE 20910 U.S.A. Funeral death 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or item in hinry or other treumatic event, its Medical Earnmen Black, Whita, atc. 1 XYas 2 No If Yas, Giva 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: p 3 Widowad 4 Divorced Yaar or Datas: 1960-62 WHITE Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 12 HANDYMAN LANDSCAPING 17. Fathar's Name (First, Middla, Last) 18 Mother's Nama (First Middle Maiden Sumama) Be HUNTER **PUTNAM** HELTZEL KATHERYN RALSTON 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) KATHERYN R. HELTZEL/MOTHER 739 SILVER SPRING AVE. SILVER SPRING, MD 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 15/17/99 ROCKVILLE, MARYLAND PARKLAWN MEMORIAL PARK 21. Signature of Funeral Service Lice 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) brovasuu Examiner Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): certificate be exec Box 68760. Physician/Medical 8 Due to (or as a consequence of): ä Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown È 1 ☐ Yes 2 ☐ No ģ 24b. Were autopsy findings available prior to Completed 24s. Was an autopsy completion of cause of death? 2 12 No † ☐ Yes 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4□ Nursing Home 5□ Residence 6 □Other (Specify) Certification: To 1 | Inpatient 2EP/Outpatient 3□ DOA ä 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 26a. Date of Injury (Month, Day Year) 28c. Injury at Work? After Attending 5 Pending investigation 1 Myatural 1 Yes 2 No death. Hospital or Attendi 24 hours after death Funeral Director: A 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28s. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a, Certifier 29b. Signature and title of certifie 29c. Licensa number 29d. Data signed (Month, Day, Year) MDME 000128 30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print) Pai BRECHER

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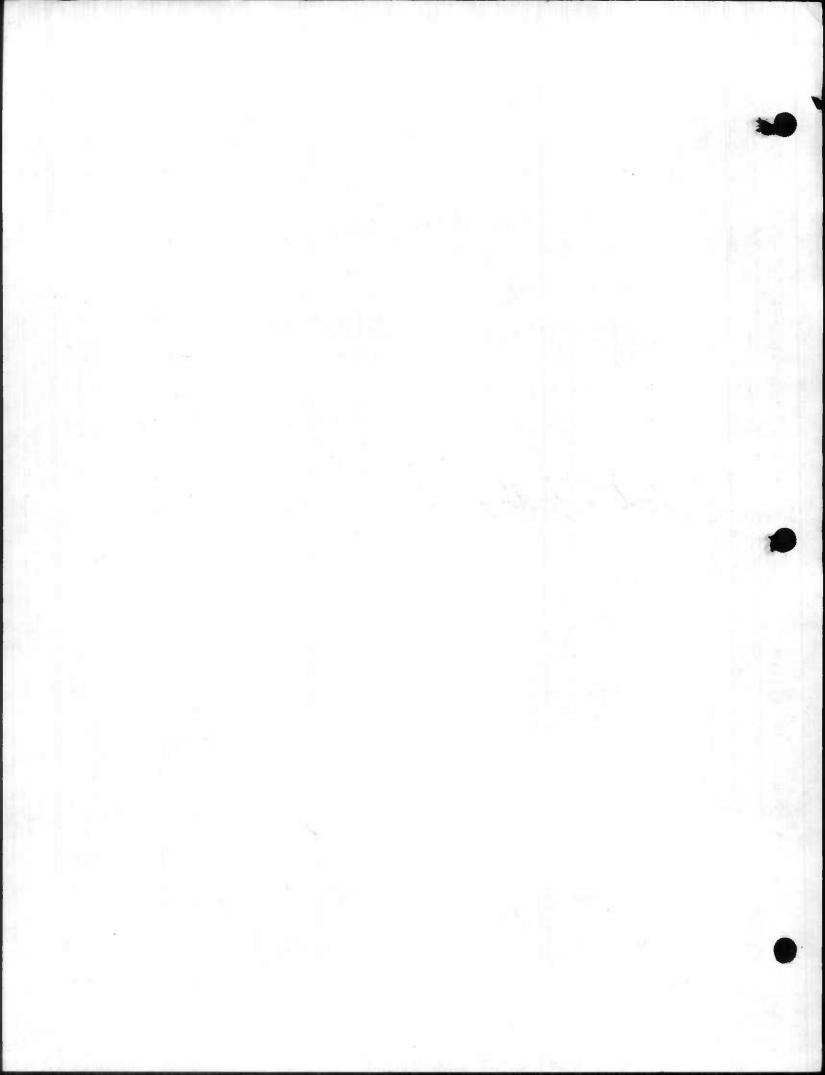
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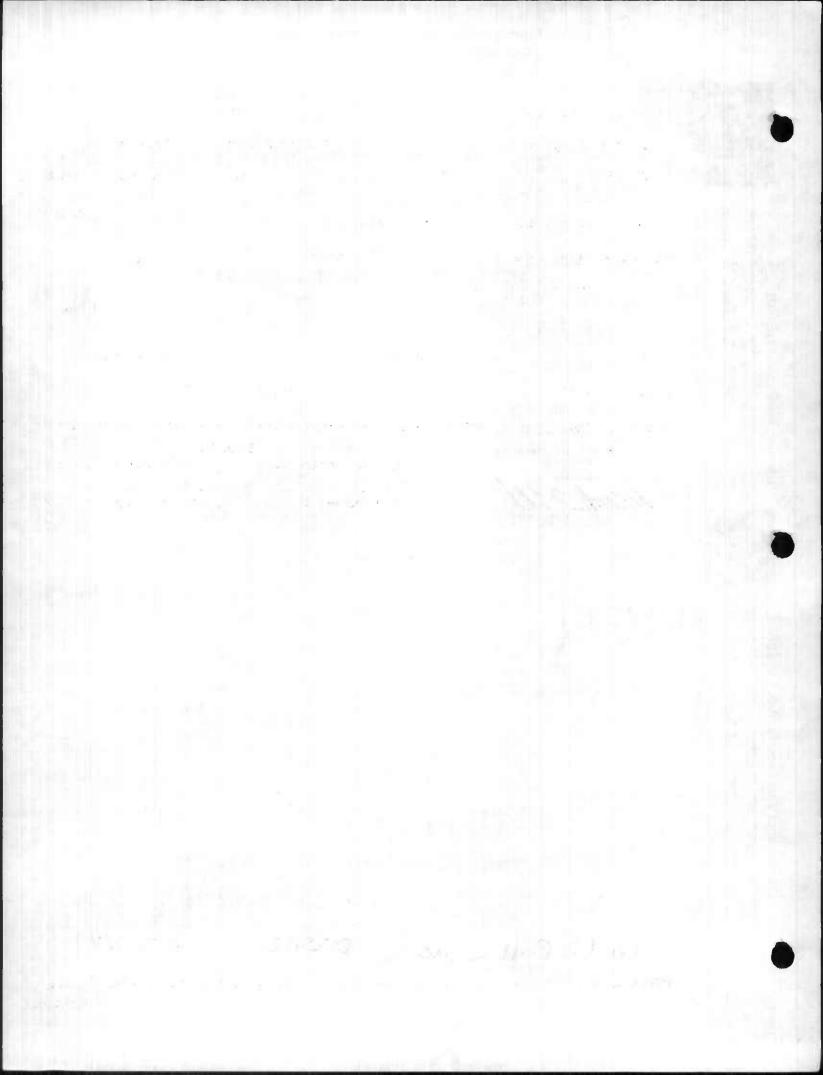
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32. Registrar's Signatura



State of Maryland / Department of Health and Mental Hygiene

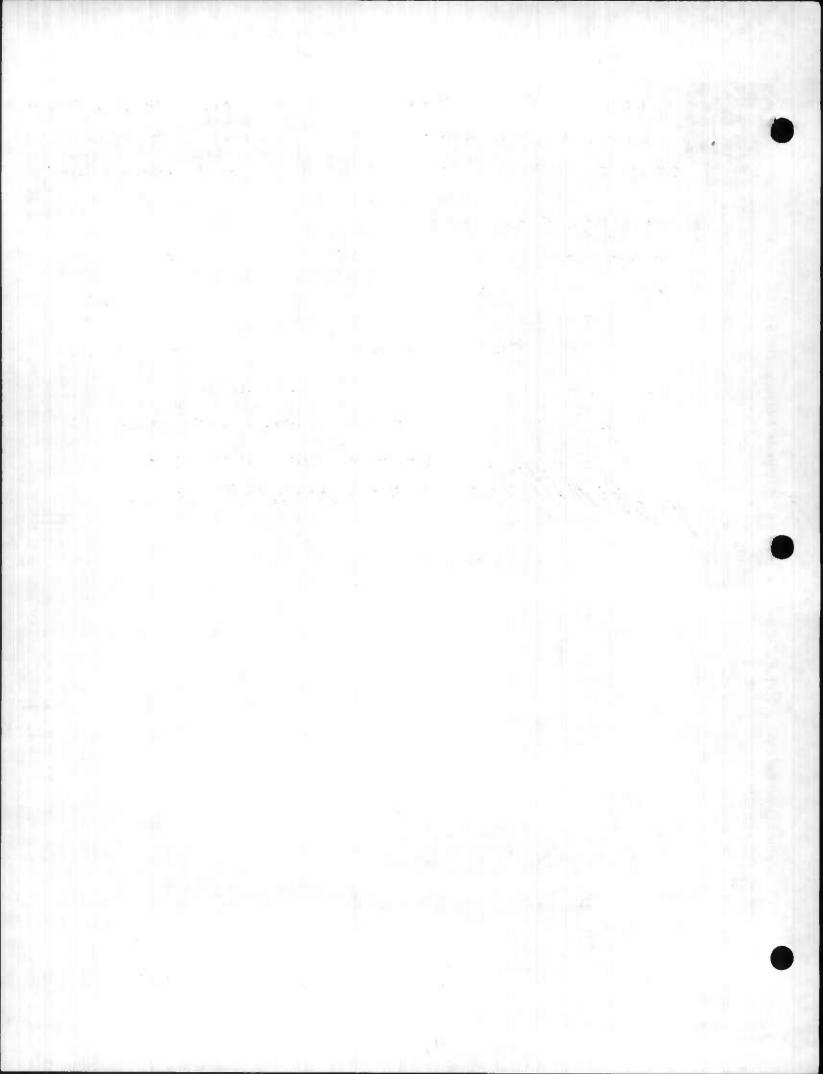
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State of Maryland / Department of Health and Mental Hygiene

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ral tor	578-14-2623	Sex 7. A 1 → M 2 □ F	lge (In yrs. last bir 90	Yrs. If Under 1 Your Months Da	ear If Under 24 H		, 1908	9. Birthplace (State or Foreig Country) North Carolina		
	Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Location				10d. Inside City Limit		
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by Funeral Director	10e. Street and Number			10f, Zip Coo	ie		10g. Citizen of V	Vhat Country?		
<u>e</u>	7905 Crows Nest	Court		2070	7		United	States		
by Funeral	11. Marital Status  1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 ☐ Yes ※ If Yes, Give Year or Dates	XNo	13. Was Decedent If Yes, specify (	of Hispanic Origin? Cuban, Mexican, Pue No Specify:	(Specify Yes or No- erto Rican, etc.)		e - American Indian, kk, White, etc.		
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	Charlie Wells, g			905 Crows						
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Physician/Medical Examiner	Immediate Ceuse (Finel disease or condition resulting in death)  Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or as a d	consequence of):  consequence of):  consequence of):	1 n fe	(*) (*) (*) (*) (*) (*) (*) (*) (*) (*)	tobacco uae co	few of		
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	4 Homicide  29a. Certifier  1 Certifying P		etc. (Specity)	, death occurred et th	e time date end ola	City or To		anner as stated.		
edicai			of examination an					and due to the cause(s)		
W	29b. Signature and title of certifier	rozaj	mo		cense number	31	29d. Date signe	d (Month, Day, Year)		
	30. Name and address of person who	completed cause of	deeth (Item 23e)	(Type, Print)	0 044	-T-1: 1		mD 20707		

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MAY 18, Physician 10:45 AM HOLVERSTOTT LAWSON W. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner MONTGOMERY BROOKEVILLE 3101 HOLIDAY DRIVE Birthplece (State or Foreign Country) If Under 24 Hrs. If Linder 1 Year 8. Date of Birth (Month, Day Year) April 17 1910 5. Social Security Number 7. Age (In yrs. last birthday) Days Months Hours Iowa 1 M 2□ F 559-10-2028 89 Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery Brookeville 1 Yes 2 No Funeral Director 10f Zip Code 10g Citizen of What Country? 10a. Street and Number 3101 Holiday Drive 20833 United States Raca - American Indian, Blsck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 M Yes 2 No 1927 – If Yes, Give Year or Detes: 1929 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 Electrician Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Charles Holverstott Emma Florence Ulrich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jewell Holverstott / Wife 3101 Holiday Drive, Brookeville, Maryland 20833 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremetion 3 ☐ Removel from State 5/19/99 Alexandria, Virginia Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signtifule of Funeral Service Line 22. Name and Address of Facility Muriel H. Barber Funeral Home P.O. Box 5038, Laytonsvill

23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Laytonsville, Maryland 20882 Immediate Cause (Final 4 months disease or condition resulting in death) Stroke Due to (or es a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were sutopsy findings available prior to Completed 24a. Wss sn sutopsy performed? completion of cause of desth? 1 ☐ Yes 2 ☑ No 1 Yes 2 KNo 8 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2K No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 PResidence 6 Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury st Work? 1 (SNatural 5 Pending investigation 1 TYes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 125 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) end manner as stated. Iner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and manner ststed. (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of pertilior 29c. License number MAY 19, 1999 D 39190 mD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Division of Vital Records, P.O. or Attending Physician: within 24 hours after death.

To the Funeral Director: All completely filled in by the fu Hospital complately To the

The law requires that the death cartificate be executed

Box 68760,

Funeral

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Pages 1 and 2 should be filed within 72 hours atter and of Meatin and Mental Hoppien.

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Department of important: If any injury or action

**Physician** 

/Medical

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page 2

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21215-0020

Baltimore, Maryland

State Registrar

J. Garrett Reilly,

MAY 20 1999

31. Date filed (Month, Day, Year)

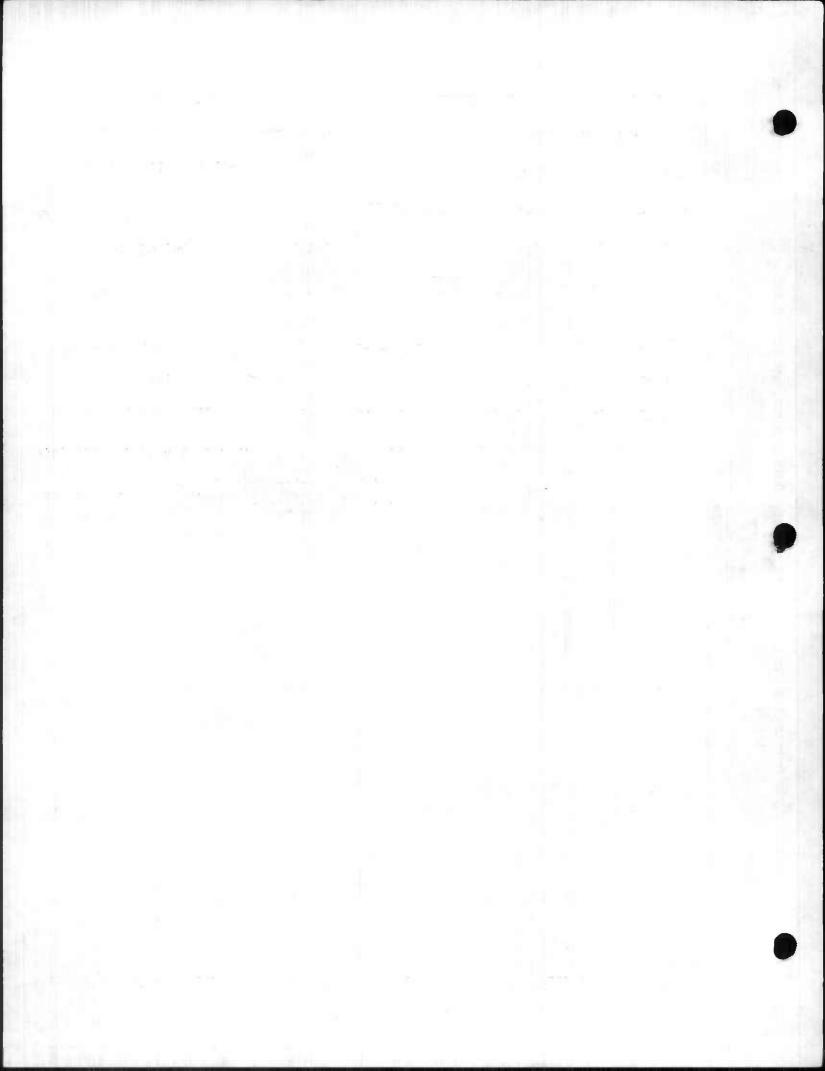
M.D.

32. Registrar's Signature

**DHMH 16 Rev 6/95** 

12+1

11510 Old Georgetown Rd., Rockville, Maryland 20852



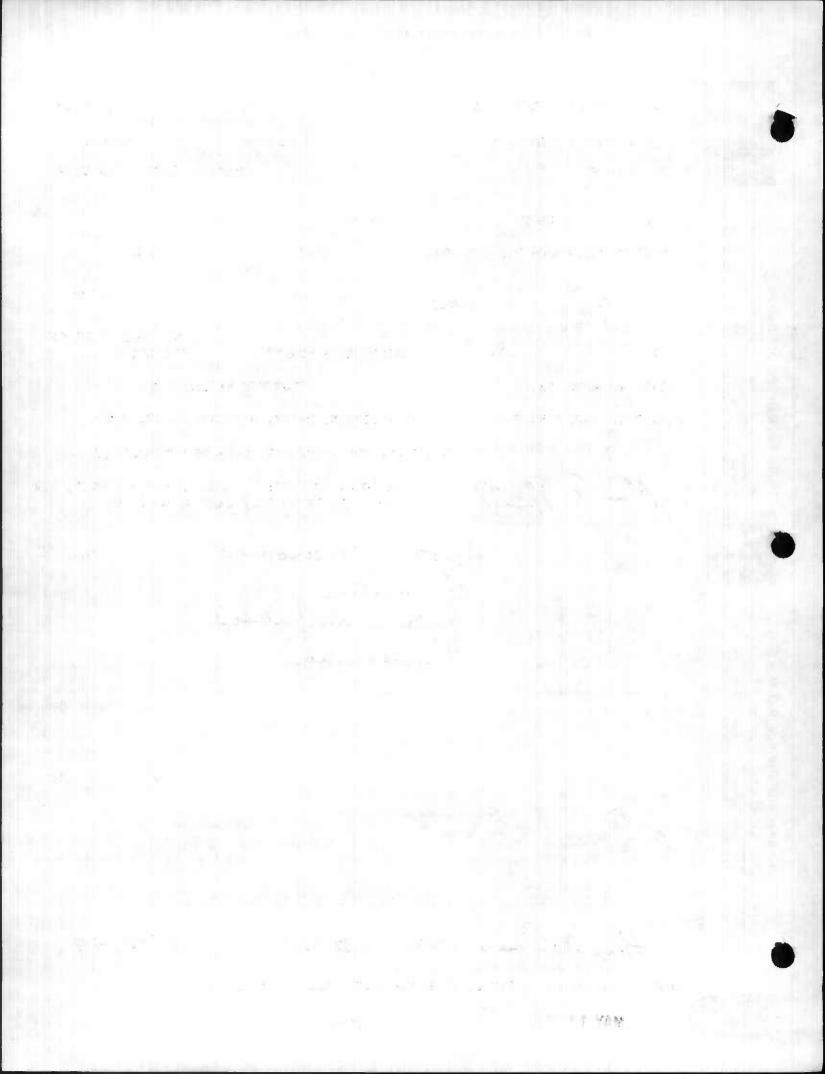
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Year **Physician** HENRY EUGENE 18 HOCK, JR. May 0125 1999 /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Talbot The Memorial Hospital Easton 8. Date of Birth (Month, Day, Year) MAR. 18, 1931 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** NEW YORK 1XXM 2 F Months Days Hours 68 132-24-3660 Yrs **Director** Usual Residence of Decedent with the Marylend 10d. inside City Limits r 28a-f show 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes XXNo Director MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23s or traumatic systit, the Medical Examiner must be 6543 PEACHBLOSSOM HEIGHTS ROAD 21601 USA Peges 1 and 2 should be filed within 72 hours after death tent of Health end Mental Hygiene. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1√√xes 2 □ No If Yes, Give Year or Dates KOREAN Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indian. Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0020 1 Yes 2X No Specify: WHITE Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) NEW YORK BOARD OF College (1-4or 5+) Elementary/Secondary (0-12) MAINTENANCE WORKER **EDUCATION** 12 -0-18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be HENRY E. HOCK, SR. FLORENCE FITZPATRICK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) GERARD W. HOCK / BROTHER 70 PINEPOINT DRIVE, BRIDGEPORT, CT. 06606 Health em 27 i other Baltimore. Hem 20a. Method of Disposition 20b. Place of Disposition (Name of Dete 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from Stete permit, Pege Department of Important: If any injury or = 5 CHESAPEAKE CREMATION CTR. 5-18-99 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Septice Licens 22. Name end Address of Facilit FELLOWS, HELFENBIEN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death **Physician** immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Examiner physicien end the burial-transit thet the death certificate be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of) Box 68760 Physiclan/Medical Due to (or as a consequence of) attending pl signed by the a 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Division of Vital Records. P.O. 3 □ Probably 4 ☑ Unknown 1 ☐ Yss 2 ☐ No þ The law requires 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed s certificate has b director, page 2 s 1 Yes 2 No 1 Yes 2 No Hospital or Attanding Physician: 24 hours after death. Funersi Director: After this certifica staly filled in by the funerel director, 25. Was cese referred to medicel examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2/20No 1 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1) Naturai 5 Pending Investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di-completaly filled in 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 0 aus, mo D53111 un 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) HUNG T. DAVIS, M.D., 219 S. WASHINGTON ST., EASTON, MD 21601 31. Date filed (Month, Day, Year) 32. Registrar's Signature

**DHMH 16 Ray 6/95** 

Registrar

MAY 1 8 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY **Physician** Thomas Fred Izzo, Sr. 0922 /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not Institution, give street and number) 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO | House 1 Year | Hours 24 Hrs. | 8. Dete of Birth Months Days Hours Min. | March 13,1927 | New Jersey 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In vrs. last birthdev) Birthplace (State or Foreign Country) **Funeral** Yrs. 202-18-5173 72 Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits YOYes 2 No Directo Delaware Sussex Ocean View 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? than "natural", or items 23s or the Medical Examiner must be 10 Clover Lane USA 19970 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 (2) Yes 2 □ No 1952 − If Yes, Give Year or Dates: 1954 14. Rece - American Indian. 11. Maritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: Specify: by 3 XWidowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondery (0-12) Coilege (1-4or 5+) Maintenance Supervisor Paper Processing 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mental Fred Izzo Mary Bosco 19b. Malling Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Nors 27 Thomas F. Izzo, Jr./Son 713 Elmtree Lane, Claymont, DE 19703 20b. Placa of Disposition (Neme of cemetary, cremetory or other pleca) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State ortant: If I 5 ☐Other (Specify) Lawncroft Cemetery 5/20/99 Linwood, Pennsylvania 4 Donation 21. Signature of Fuheral Service License 22. Name end Address of Facility Zeller Funeral Home, P. O. Box 3171, oncus 1212 Old Ocean City Road, Salisbury, MD 21802 Enter the disease, or conducations that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, it, or haart failura. List only one cause on each line. Approximate Intarvel Between Onset and Death **Physician** a MULTI-ORGAN FAILURE /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequenca of): Examiner HYPOTENSON and I-transit Sequentially list conditions, if any, laading to immediate causa. Entar Undarlying Cause (Disease or injury that initiated evants resulting in death) Last Due to (or as a consequence of) physician ar WITEM SY CASS DRINKRY Physician/Medical Due to (or as a consequence of): 88 for use es 3887X1 () Kaso Colonke signed by the a d be detached f Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 Dunknown CENAL PRITTER WENTER CRENCES à 24b. Were autopsy findings eveileble prior to should should Completed 24a. Was an autopsy completion of cause of deeth? ils certificate has l director, page 2 s 1 Yes 2 No 1 Yes 2 No al or Attending Physician: T s after death. it Director: After this certificat ed in by the funeral director, p 25. Wes case raferred to medical examiner? Be 26. Place of Deeth (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Dey Year) 1 Naturai 5 Pending 1 Yas 2 No Invastigation 2 Accidant 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicida To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b. edicai 🕍 🔭 my ng Physician: To tha best of my knowledge, death occurred at tha time, date and placa, and due to tha causa(s) and menner as stated. 29a. Cartifiar Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. DAMES TON 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

201 PINE BLUFF 32. Registrer's Signature MAY 2 0 1999

30. Name and address of person who complated cause of death (Itam 23a) (Type, Print)

Told

31. Date filed (Month, Dey, Year)

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Salisbury Md. 21801

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**DHMH 16 Rev 6/95** 

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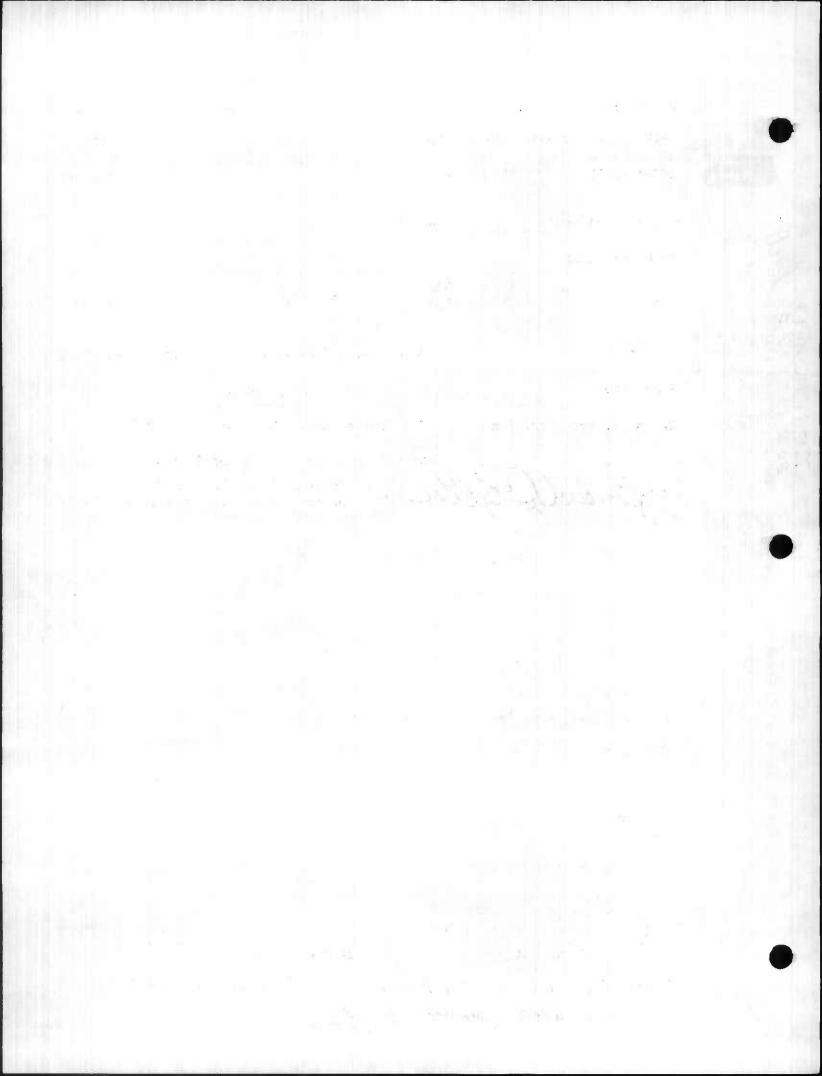
that the death certificate be executed

law requires

P.O. Box 68760,

Records,

Division of Vital



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middle, Last) 2. Data of Daeth **Physician** Month ones Jub /Medical 4a. Fecility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Nursing Alice B Tawes omerse If Undar 1 5. Social Sacurity Number (myrs. last birthday) 8. Data of Birth (Month, Dey, Year) 7. Aga **Funeral**  Birthplaca (Stata or Foreign Country) 1□M 2 Months Hours Devs 212-10-4691 93 Director April 12, 1906 Maryland Usual Rasidence of Dacedant with the Marylend 10a. Stata 10b. County 10c. City, Town or Location 28a-f show 10d. Insida City Limits traumatic event, the Medical Examiner must be notified at Maryland Somerset Crisfield Director Yas 2 No 10e. Street end Numbar 10f. Zin Coda 10g. Citizen of What Country? ò 115 W. Chesapeake Avenue 21817 U.S.A. Herna 23a permit. Pages 1 and 2 should be filed within 72 hours after deeth in Department of Health and Mentel Hygiene. Important: If flem 27 is marked other than "natural", or itema 23s any injury or other traumatic event. Funerai 12. Was Decedent Ever in U,S. Armed Forcas? Was Dacedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amaricen Indian. Black, Whita, etc. 1 ☐ Yas 2 ② No If Yas, Giva Year or Datas: 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 White 1 Yas 2 No by 3 Widowad 4 Divorced Completed 16a. Dacedant's Usuai Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 15. Decadant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collaga (1-4or 5+) Grade 9 Homemaker At Home 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nema (First, Middle, Maidan Surnama) Be William W. Riggin Bertha Brittingham 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Robert E. Jones (Son) 1806 S. Mill Drive - Salisbury, MD 21804 20b. Placa of Disposition (Nama of cematary, crematory or othar placa) 20e. Mathod of Disposition 20c. Location - City or Town, Stata 1X Burial 2 Cramation 3 Ramoval from Stata 5/20/99 4 ☐ Donation 5 ☐ Othar (Specify) Sunnyridge Memorial Park Crisfield, MD 21. Signature de luberal Service Lice 22. Nama and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, MD fi. Bradshaw, 21817 Robert H. Bradshaw. J. 306 W. Main St. - Crisfield, 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Robert Approximata Intarval Batween Onset and Death **Physician** /Medical Immedieta Causa (Finel ASCVD diseasa or condition resulting in death) **Examiner** Due to (or as a consequence of) or Attending Physician: The law requires that the deeth certificate be axecuted the burial-transit Sequantially list conditions, if any, leeding to immadieta causa. Entar Undarlying Causa (Disaasa or injury that initiated events rasulting in deeth) Last and Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es a consequança ot): 80 been signed by the ette should be deteched for Part if. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CHE by 24b. Were autopsy tindings available prior to completion of causa of death? Completed HIN 24a. Was an autopsy performed? After this certificate hes 250 No 20X No 1 Yas 1 Yes Be 25. Was casa retarrad to medical 26. Pleca of Death (Check only ona) Other: 10 1 ☐ Yas 20 No 1 Inpatiant 2 ER/Outpatient 3 DOA 4⊠Nursing Homa 5□ Rasidance 6 □Other (Specify) 27. Mennar of Death Medical Certification: 28a. Date of injury (Month, Day Year) 28b. Tima ot 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Pending invastigation 1 Natural within 24 hours efter death.

To the Funeral Director: A completely filled in by the ft death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicida 28a. Place of Injury - At home, farm, streat, factory, office building, atc. (Specify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida the Hospital 29a. Cartifier Ecrifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha cause(s) and menner as stated. 2 Medical Examiner: On the basis of axaminetion end/or invastigetion, in my opinion, daath occurred et tha time, dete end pleca, and dua to the causa(s) and manner stated. 29b. Signetura and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) D 48098 0 30. Nama and address of person who complated causa of deeth (Item 23a) (Type, Print)

State Registrar 31. Data tiled (Month, Day, Year) MAY 1 8 1999

32. Ragistrer's Signatura

B. Sporks

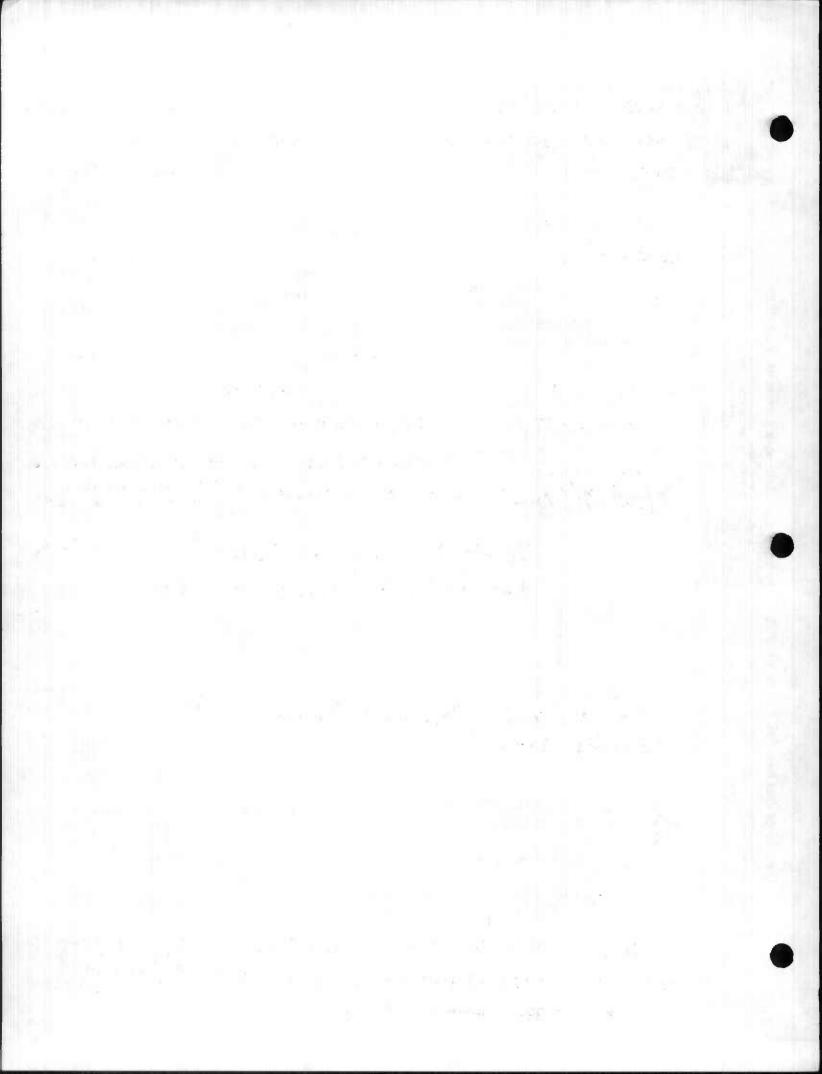
Vijay Karumbunathan, M.D. - 201 Hall Highway - Crisfield, MD

THE REAL PROPERTY OF THE PROPE

MAY 1 8 1838 James E. Married

State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month **Physician** MAY 13 DOROTHY ELAINE KEPLER 1999 2:45 AM /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JULIA MANOR HEALTH CARE CENTER HAGERSTOWN WASHINGTON 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 M F 84 Director 220-16-2730 MAY 13, 1915 VIRGINIA Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits r than "natural", or items 23s or 28s-f short The Medical Examiner must be notified at 1 X Yes 2 □ No Directo MARYLAND WASHINGTON HAGERSTOWN 10g. Citizen of What Country? 10e, Street end Number 10f. Zlp Code 21740 333 MILL STREET death v U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American indian, Black, White, etc. 12. Was Decedent Ever In U.S. Armed Forces? 11. Mentel Status 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 21 No Specify: Specify þ 3 Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within the permit and Mentel Hygiene. Important: If item 27 is marked other than any injury or other traumatic avant Elementary/Secondary (0-12) College (1-4or 5+) 11 HOMEMAKER OWN\_HOME 18. Mother's Name (First, Middle, Meiden Sumame) 17. Fether's Name (First, Middle, Last) Be LABAN P. THOMAS FLORA ALIFF 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informent's Name/Reletionship (Type, Print) FUNERAL HOME RECORDS 7606 OLD NATIONAL PIKE, BOONSBORO, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 5/19/99 BOONSBORO, MARYLAND BOONSBORO CEMETERY 21. Signature of Funeral Service Cidensee 22. Name and Address of Fecility 7606 Old National Pike BAST FUNERAL HOME Paul M. Dean Boonsboro, Maryland 21713 23a. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medicai immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner the deeth certificate be executed physician end the buriel-transit Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): 80 esn 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given In Part I. 1 Yes 2 No 3 Probably 4 Unknown LOU þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? certificate Division of Vital 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospital: 1 Yes 2 No 27. Manner of Death Other: Nursing Home 5 Residence 6 Other (Specify) 10 1 Inpatient 3□ DOA 2 ER/Outpatient this funeral 28a. Date of injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred 28b Time of After 1 Certification: 1 Naturel 2 Accident or Attanding 5 Pending 24 hours after death. Funeral Director: Af 1 Yes 2 No investigation 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Placa of injury - At home, farm, street, factory, offica building, etc. (Specify) 4 | Homicide Hospital edical 29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as stated. completely 2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the ceuse(s) and manner stated. (Check only one) within 2 the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 910 IIIID ME EICKLAMPUS ROAD, HALLER 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 00 DELA/ORTAS

State Registrar 31. Date filed (Month, Day, Yeer)

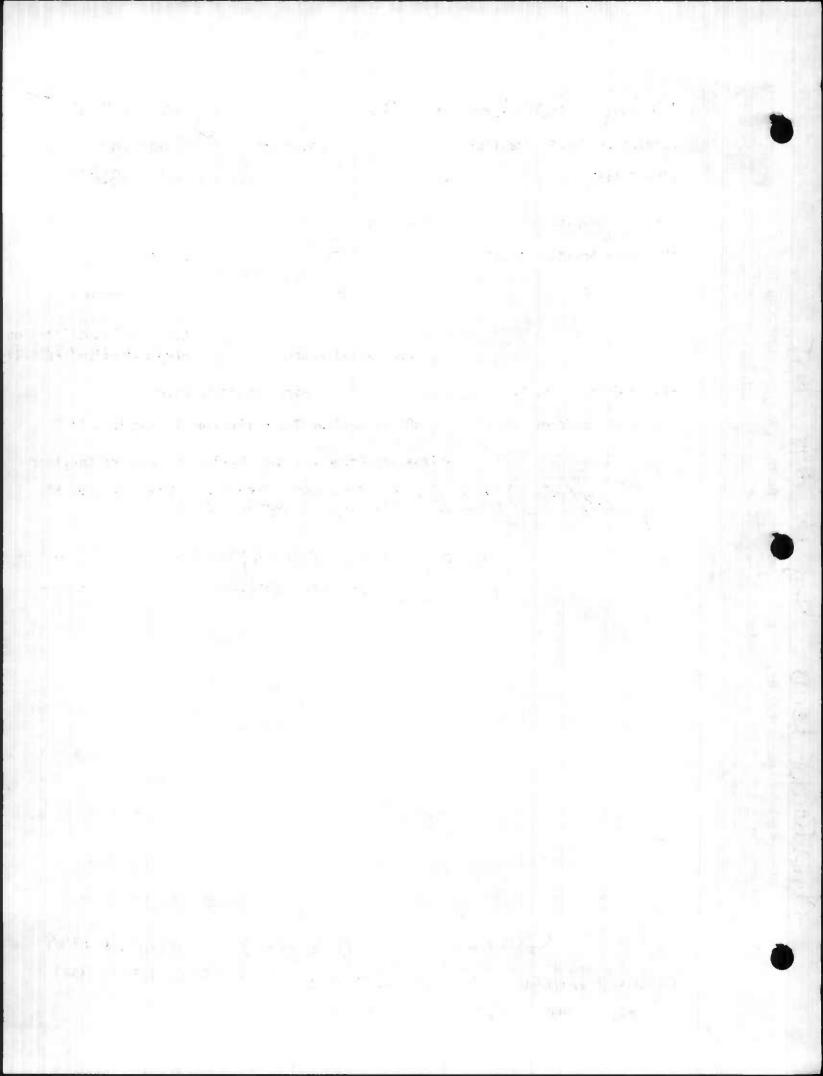


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Dete of Death 3. Time of Death Month **Physician** Randolp Philip Randoff

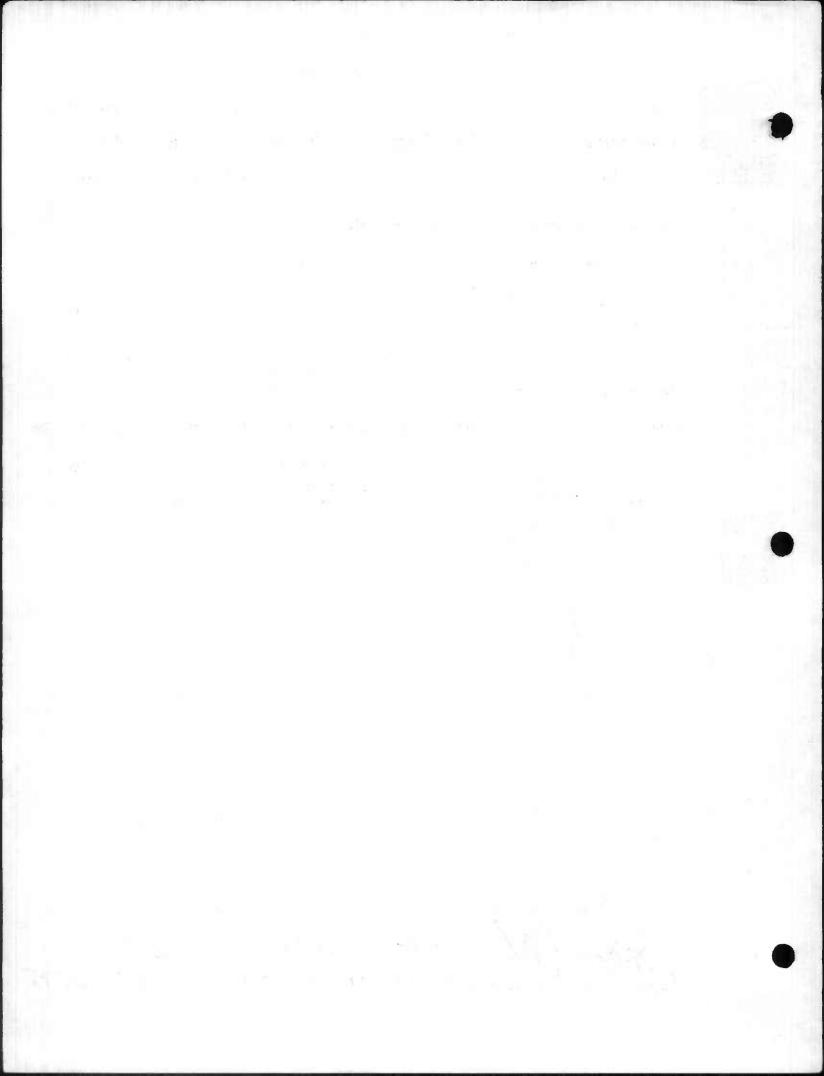
4a Facility Nama (If not institution, give street and number) Mar /Medical 4c. County of Death 4b. City, Town, or Location of Dear Examiner Washington County Hospital Hagerstown ar IrUnder 24 Hrs. s Hours Min. Washington

9. Birthplace (Stela or Foraign
Country) 8. Deta of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Yaar 7. Aga (In yrs. last birthday) 6. Sax **Funeral** 1□ M 2□ F Months Deys Mary land Yrs. **Director** 218-38-1112 58 Sept 4, 1940 Usuel Rasidence of Daceden the Marylend 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 1 Yas 2 □ No Director Maryland Washington Williamsport 10e. Street and Number 10f. Zip Coda 10g. Citizan of Whet Country? must be n 409 South Artizan Street 21795 U.S.A. Funeral death 12. Wes Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva 7 is marked other than "natural", or items traumatic event, the Medical Examiner m Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puarto Rican, atc.) 14. Race - Amarican Indian, 11 Meritel Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or ant of Health and Mental Hygiene.
nt: If Item 27 ie marked other than "natural", or Itei 1 Naver Married 2 X Married Specify: White 1 ☐ Yas 2 No Specify: þ 3 Widowad 4 Divorced Yeer or Detas: 16a. Decedent's Usual Occupation 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grade complated) (Giva kind of work dona during most of working lifa. DO NOT usa ratired) Airplane Rehabilitation Elamantary/Secondary (0-12) College (1-4or 5+) Facility Sheet Metal Mechanic 9 0 18 Mothar's Nama (First Middle Maiden Surnama) 17. Fathar's Nama (First, Middla, Last) Winton Harry Kerns Sr. Mary Catherine Dutrow 19e. Informant's Name/Ralationship (Type, Pnint) 19b. Meiting Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda) Devona Irene Kerns 409 S. Artizan St. Williamsport, Maryland 21795 /Wife 20b. Plece of Disposition (Name of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Ramovel from Steta Smithsburg Crematory May 16,1999 4 □ Donetion 5 □ Other (Spacify) Smithsburg Maryland 21. Signature of Funeral Service Licenses 22. Nama and Address of Fecility Osborne Funeral Home 425 S. Conococheague St. Enter the disvase, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory errest, or haert faltura. List only one cause on each line. Approximata Interval Between Onset end Deeth **Physician** /Medical Immediata Cause (Finet Thunkes Myocardin diseasa or condition rasuiting in daath) Examiner Examiner 1 chemic physician end the burial-transit Sequantially list conditions, if eny, leading to immadiata ceusa. Entar Undarlying Causa (Disaesa or Injury that initialed avents rasulting in death) Last Physician/Medical Dua to (or as a consequenca of): attending pl Philip Kandof Yems signed by the at d be detached for Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy this certificate hes 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa raterrad to medical Be 28. Placa of Death (Chack only ona) axaminari Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Tes 2 No 1 ☐ Inpatiant 2 DER/Outpatient 3 ☐ DOA 27. Manner of Death Date of tnjury (Month, Dey Year) 28c. tnjury at Work? 28b. Tima of 28d. Dascribe how injury occurred Certification: 1 Natural 5 Panding invastigation 1 ☐ Yas 2 ☐ No 24 hours after death Funerel Director: 2 Accidant 3 Suicida 6 Coutd not be detarmined 28f. Location (Street and Number or Rural Routa Numbar, City or Town, State) 28a. Piece of Injury - At home, farm, street, factory, office building, atc. (Spacify) 4 Homicida To the Hospital within 24 hours a To the Funeral Completaly filled 1 Certifying Physician: To the best of my knowledge, daath occurred at tha tima, data and place, and dua to the cause(s) and mannar es stated.
2 Medical Examinar: On the basis of axamination and/or trivastigation, in my opinion, daeth occurred at the time, dete end place, and dua to the cause(s) end mannar statad. 29a. Certifier edical 29d. Data signed (Month, Day, Year) 29c. Licansa number 29b. Signatura and titta of cartifier up-12-821-OAK HI(ME. HAGERSTOWN. M) 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) ABOUL WATERD 31. Data filed (Month, Day, Year) 32 Registrar's Signatura State MAY 17 1999 pours Registrar

3

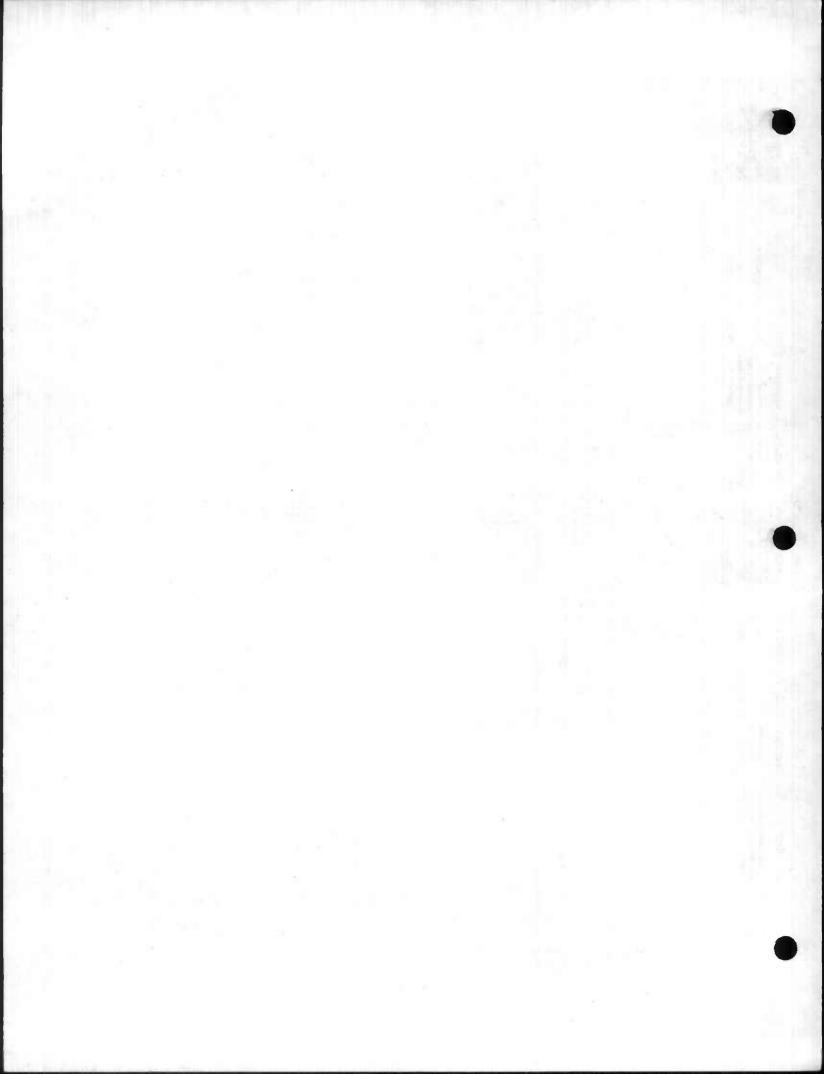


			State of Maryland / Department of Health a  Certificate of Death		iene	17490
	Physici /Medi		1. Decedant's Nama (First, Middle, Last) Patricia Kasson	2. Date of Deat Month May	Day Yea	
	Examir Funeral Director		Morines Health at Circle 1923 (also Dlace Kendington)  5. Social Sacurity Number 355-20-0532  8. Sax 1 □ M 2 □ F 7. Age (In yrs. last birthday) Yrs.  7. Age (In yrs. last birthday) Months Days Hours	n, or Location of Death  24 Hrs. 8. Data of Birth (Month, Day, July 31,	4c. County of De MONTGOME	Mhplaca (Stata or Foreign
	the Maryland r 28a-f show	Director	Usual Rasidence of Decedent  10a. Stata 10b. County 10c. City, Town or Location  Maryland Montgomery Silver Spring  10e. Street and Number 10f. Zip Coda	11	0g. Citizen ol What (	10d. Inside City Limits 1 ☐ Yas 2 ☑ No Country?
020	within 72 hours after death with the Maryland ane. than "natural", or items 23s or 28s-f show he Medical Everting must be notified at	by Funeral D	8207 Schrider Street   20910	in? (Specify Yas or No- Puerto Rican, etc.)	IISA 14. Race - An Black, Wh Specify:	nerican Indian, nita, etc. White
121215-0020	77 70 6 20	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  5+  Instructor  18. Mother	of working	16b. Kind of Busines	s/Industry
Maryland	d 2 should be h and Mental f is marked o traumatic eve	To Be	Constantine Kasson Mar  19a. Informant's Na <i>me</i> /Relationship ( <i>Type, Print</i> )  19b. Mailing Addrass ( <i>Street</i> and <i>Number</i>	r or Rural Route Number	City or Town, State	
Baltimore,	it. Pages 1 arment of He		Thomas C. Kasson (brother) 3810 Kelsey Street  20a. Method of Disposition  1  Burial 2  Cremation 3  Ramoval Irom Stata  4  Donation 5  Othar (Specify)  21. Signature of Funaral Sarvice Light State  Burial State  Canada State	Data 5/17/99 S	20c. Location - City of	or Town, Stata
Ba	Deme Depa impo any ir		Francis J. Colli  100 University B  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as complete the disease.	ns Funeral Slvd.,W.,Sil	ver Sprin	
	Physician /Medical Examiner	er	shock, or haart failura. List only one causa on each lina.  Immediata Cause (Final disease or condition resulting in death)  a. Jastrountestual Hemsta	hoge		Interval Between Onsat and Death
Box 68760,	eath certificate be executed attending physician and for use as the burial-transit	n/Medical Examiner	Sequantially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Diseasa or Injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):			
P.O.	es that the digned by the	by Physician/M	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. <b>Did to</b>		rta to the cause of death? Probably 4 Unknown
al Records,	The law requate has been page 2 shou	Completed		24a. Was a perform	ned?	D. Wara autopsy findings svaliable prior to completion of cause of death?  1  Yas 2 No
on of Vital	ding Physician; Th. h. After this certificate funeral director, pag	ion: To Be	examinar/ 1			pecify)
Division	eat the	i Certification:	2 Accident invastigation 3 Suicide 6 Could not be datermined 28e. Place of Injury - At home, farm, streat, factory, offica building, etc. (Specify)	28l. Location (St City or Town	n, State)	Rural Route Number,
	To the Hospital or Att	Medical	29a. Certifilar  (Check only one)  To Certifying Physician: To the best of my knowledga, daath occurred at tha time, date and 2 Madical Examinar: On the basis of axamination and/or invastigation, in my opinion, daath and manner stated.  29b. Signature and title of cartifier  29c. Licensa number	h occurred at tha time, di	ause(s) and mannar ate and place, and d	ue to tha cause(s)
	5		30 Name and address of pareon who completed cause of death (Item 23a) (Type Print)  ASNER MD 3720 FARRAGOT AL	IE KENSIN	5/13/9 16TON P	9 1D 20895
	Sta Registr	_	31. Date filad (Month, Day, Year)  32. Begistrar's Signature			



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1. Decedant's Nama (First, Middle,	Last)		rtificate of		2. Deta of De	_		3. Tima of Death
Physician /Medical	Ivalii Siin	Kim				Month May	Psy 19	99	5:50 A.M
Examiner	An Caritte Blance Manakinskins	nive street end number)			4b. City, Town, or Loc	cation of Death	4c. County	of Death	
	4949 Battery La	ne #107			Bethesda		Mont	gomer	·v
Funeral	5. Sociel Sacurity Number 6	Sex 7. Age (In	yrs. last birthday)	If Under 1 Year Months Days		8. Deta of Birt (Month, Da	h	9. Birthplac	ce (State or Foreign
Director	575-23-4051	50	Yrs.		F	eb. 11		_	Korea
B 8-	Usual Residence of Decedant  10a. Stata 10b. County	10	c. City, Town or Lo	cation				100	d. Inside City Limits
d'any	Manufand Mantas								1 ☐ Yes 2 ☑ No
or 28a-f	Maryland Montgo	mery	Bethesd	10f. Zip Code			10g. Citizen of W	hat Country	v?
		. #107		2001	,				
r theme 23st siner must	4949 Battery Lan	12. Wes Decedent Evan	in U,S. 13. \	20814 Was Decedent of H	† lispanic Origin? (Spe an, Mexican, Puerto F	cify Yes or No	USA 14. Raca	- American	
Fur Fur		Armed Forces? 1 ☐ Yas 2 ☑ No				Rican, etc.)		c, Whita, ato	c.
within 72 hours after one. then "netural", or the he Medical Examina ormolested by Fu		If Yas, Giva Year or Detas:		1 □ Yas 2½ No	Specify:		Specify:	Asia	n
yglere. Net than "neturn it, the Medical. Completed	15. Decedent's (Specify only highest)	Education	16a. Deced	dent's Usual Occup	ation during most of working	10	16b. Kind of Bu		
the same	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retired	dorang most of works	·y			
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Saba a	17. Fathars Name (First, Middle, La	st)			18. Mother's Name	(First, Middle,	Maiden Sumam	9)	
2×22 -					Pyong Sa				
s 2 sh h and h and fam reum	19a. Informant's Name/Ralationship			ng Addrass (Street	and Number or Rura	Route Numbe	er, City or Town,	State, Zip C	(ode)
f Health Nem 27 other tr	Alicia Kim  20a. Mathod of Disposition	(daughter	0b. Place of Dispo	Battery ]	Lane #107	Bethe	sda, Mary	land	20814
82=8	1 ☑ Burial 2 ☐ Cramation 3	☐Ramovel from Stata	cemetery, cren	natory or other place	>e)	Date	200. Location	City of Town	ii, Siala
semit. Pages 1 ar Department of Hea Important: if Item; iny Injury or other RIGS.	4 Donation 5 Other (Spe		Norbeck N			/17/99	Olney, 1	Mary1a	and
Dept mpo	21. Signeture of Funaral Service Lic	ensee		. Nama and Addra ancis J.	Collins F	uneral	Home, I	nc.	
	you s. L	cervo	50	O Univers	sity Blvd.	.W. Si	Lver Spr	ing.M	D 20901
	23a. Part1. Entar the disaasa, or co shock, or heert failura. List on	mplications that caused tha ly one causa on each lina.	death. Do not ent-	er tha mode of dyir	g, such as cardiac of	r respiratory a	rest,	tr	Approximata ntarval Between Onset and Death
Physician /Medical	Immediata Causa (Final							1	NISOL BING DOBINI
Examiner	diseasa or condition rasulting in daath)	a. Metastati	c Colore	ctal Can	cer			8	Months
exacuted in and tal-transit			i						
exec in an tal-tr	Sequentially list conditions, if any, leading to immediata	500	to (or as a conseq	derica or).					
law requires that the death certificate be executed as been signed by the attending physician and be should be detached for use as the burial-transit nibleted by Physician/Medical Examin	cause. Enter Undarlying Cause (Disease or Injury that initiated events	c. Dua	to (or as a consequ	uence of):					
Med the									
attending   for use as		d						1	
at the death certification of the attending elected for use a Physician/M	Part II. Other algnificant conditions	en in Part I.	23b. Did tobacco use contribute to the cause of			he cause of death?			
res that the designed by the a labe detached for by Physic						10	Yes 2⊠ No	3 Probe	bly 4 Unknown
be d									
The law require sate has been single 2 should I							an autopsy med?	availe	a autopsy findings able prior to
law law las b								of de	pletion of cause eath?
The law ate has page 2						101	ras 2 No	101	Yes 2½ No
ystclan: The securificate director, pag					26. Place of Death	(Check only o	ne)		
T Sign	1 ☐ Yas 2 ☑ No	Hospital: 1 Inpatient	2 ☐ ER/Outpatien		4 LI Nursing mon	na 5⊠ Resid	lence 8 Othe	r (Specify)	
Attanding Physician: or death. octor: After this certific by the funeral director, iffication: To Be (	27. Mannar of Death 1 ☑ Natural 5 ☐ Pending	28a. Data of Injury (Month, Day Yea	ar) 28b. Time of Injury	Wor		8d. Describe I	now injury occurr	bed	
death. ctor: After y the funer fication	2 Accident invastigat 3 Suicide 6 Could not	he	***		Yes 2 No	04 1 //	N 4 4 At b		D. 4. 4. 4 1
tal or Attanding P rs after death. al Director: After led in by the funers Certification:	4 Homicida determine	d 28a. Placa of Injury - building, atc. (S)	At home, farm, stri pecify)	eet, factory, office	1	City or Tox	Street and Numbern, State)	Prof Hurai F	Houte Number,
		hysician: To the best of my	knowledge death	occurred at the time	as data and place a	nd due to the	and and man	anne no etat	lod
he Hospi in 24 hou he Funer pletely fil	(Check only 2 Medical Expone)	iminer: On the basis of axa	mination and/or inv	restigation, in my o	pinion, death occurre	d at the time,	date and place, a	nd due to th	he cause(s)
Me dithin	29b. Signetura end titla of certifier			29c. Licens	e number		29d. Data signed	(Month, De	ay, Year)
3	AMINIAL I	La protette mer		D 22	407		Mars 15	1000	
>	30. Name and address of person wh	competed causa of death	(Item 23a) (Type	D 32 Print)	407		May 15	1999	9
	Joseph M. Hagger	tv. M.D. 970	7 Medica	1 Center	Drive Po	ckwill.	Marula	nd 2	0850
State	Joseph M. Hagger 31. Data filed (Month, Day, Year)  MAY 1 7 19	32. Registrar's S	Signatura	1 Center Sports		ckvill	Maryla	nd 2	0850



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #7,5/19/99, BMW, Montg. Co. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death KAP SOOK KIM MAY 16, 1999 8:00 P.M. 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death RANDOLPH HILLS NURSING HOME WHEATON MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours 1 M XX F 74 213-21-3219 JUNE 03, 1924 KOREA Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 ☐ Yes X No MARYLAND MONTGOMERY SILVER SPRING 10g. Citizen of What Country? UNITED STATES 10e. Streat and Number 10f. Zip Code 13700 HOBART DRIVE 20904 OF AMERICA 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Black, White, etc. 1 ☐ Yes 2 XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2010 Specify: 3XXWidowed 4 Divorced ASIAN 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HAIR SALON/ 4 BEAUTICIAN OWNED BUSINESS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BYUNG TAE KIM KAY HEE KIM 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MOON HEE KIM (SON) 13700 HOBART DRIVE SILVER SPRING MARYLAND 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) MAY 18, 20c. Location - City or Town, Stete MBurial 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1999 OLNEY MARYLAND NORBECK MEMORIAL PARK 22. Name and Address of FacilityHINES-RINALDI FUNERAL HOME, 21. Signature of Funeral Service Linear 11800 NEW HAMPSHIRE AVENUE SILVER SPRING MARYLAND 20904-2891 if the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, theart feilure/List only one cause ac each line. Approximate Interval Between Onsetand Deeth Immediete Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of):

**Physician** /Medical Examiner

and

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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must be n

b

Baltimore, Maryland 21215-0020

filed within 72 Hygiena. other than

permit. Pages 1 and 2 should be Department of Health and Mental Important: If New 27 is marked of

Directo

Funeral

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Completed

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2

bunal-tra Physician/Medical for use as 40 080 signed by t Be Completed by director Certification: To funeral ne Hospital or Attendit n 24 hours effer death. The Funeral Director: A pletely filled in by the fo

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this

The law requires that the death certificate be executed

P.O. Box 68760

Division of Vital Records,

or Attending Physician:

Part II. Other significant conditions conf	tributing to death but not res	sulting in the underlyin	g cause given in Part I.	23b. Did tobecco use	contribute to the cause of death?
Mitral Re	grugitation	ry		1 Yes 2 No	3 Probably 4 Unknow
AMIC R-	guigita	/		24a. Wes an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
atrial 60	Will the M			1□ Yes 2□ No	1 Yes 2 No
25. Was case referred to medical examiner?			26. Place e	Death (Check only one)	
1 Yes 2 No	ospital: 1   Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nurs	ing Home 5 ☐ Residence 6 ☐ C	ther (Specify)
27. Manper of Death 1 Netural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occ	urred
3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specia	ome, farm, street, fact fy)	ory, office	28f. Location (Street and Nur City or Town, State)	nber or Rural Route Number,

29c. License numbe

29d. Dete signed (Month, Day, Year)

State Registrar

31. Dete filed (Month, Day, 1999

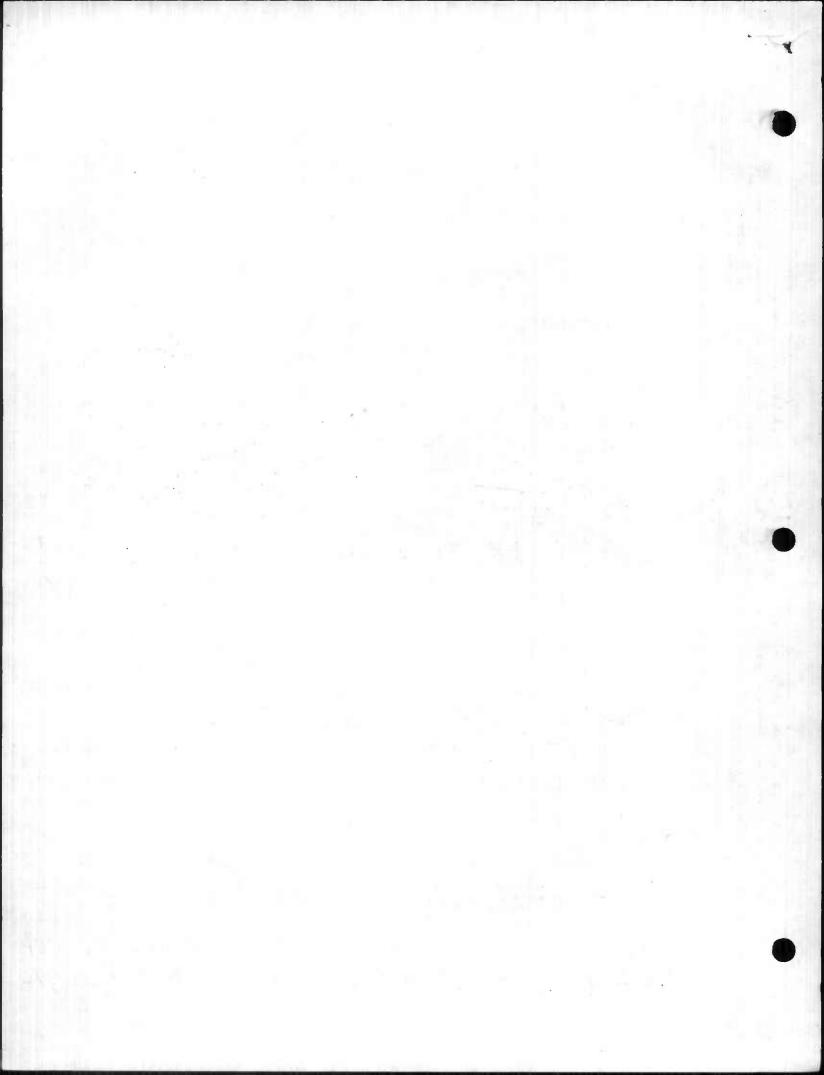
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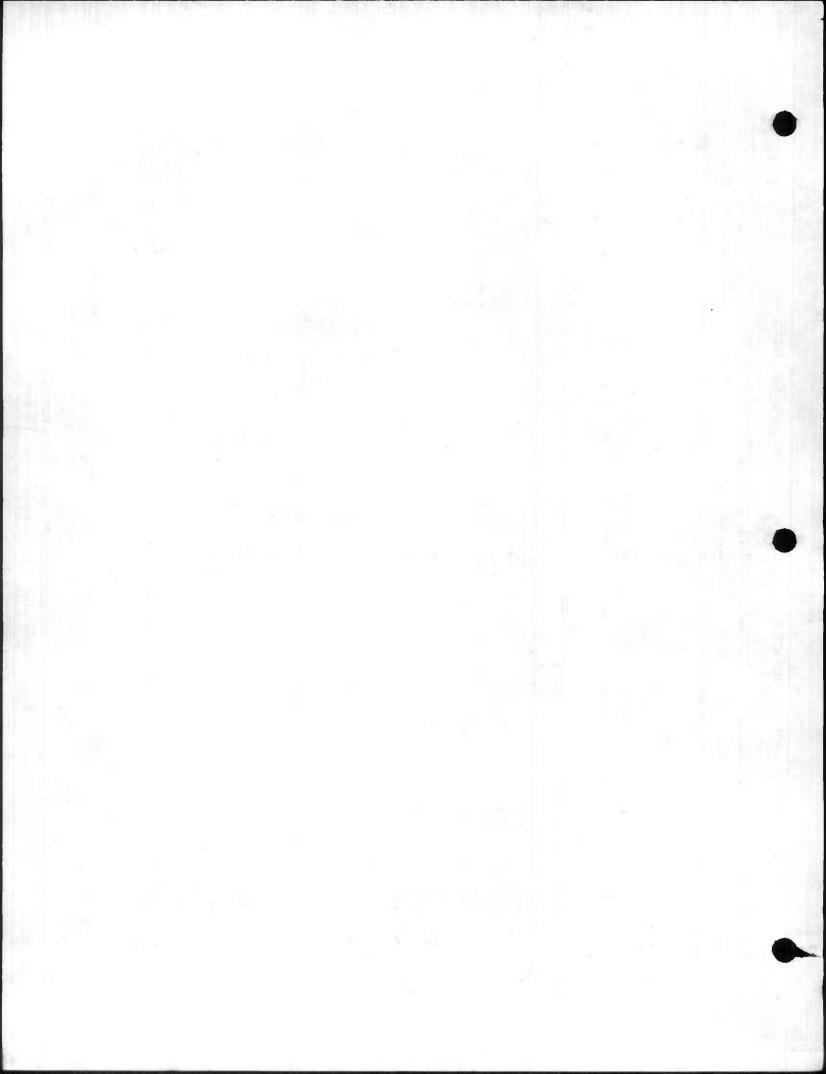
32. Registrar's Signature

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To the Hosp within 24 hou To the Fune completely fi

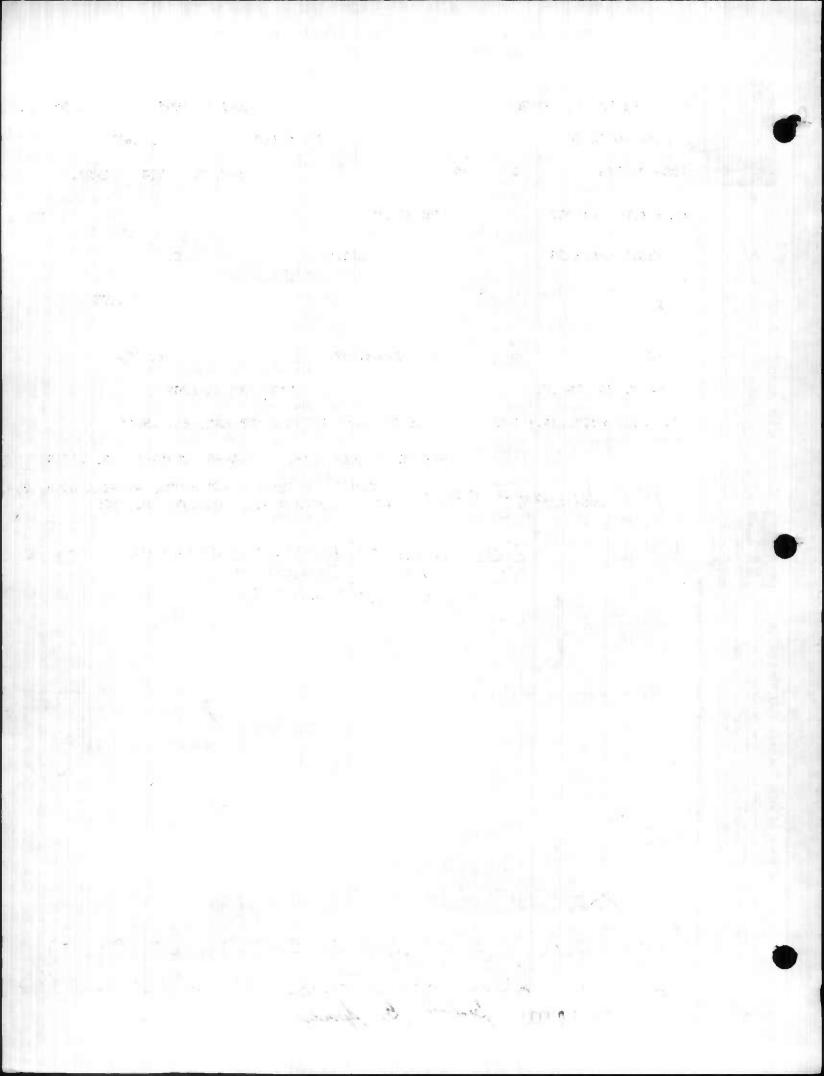


			State of Ma	aryland /	Certifica				Reg. No.	9 1	71.93
Physician	111-111-01	e (First, Middle, Last)						2. Date of De	Dev	Year	3. Time of Death  1:45 A.M.
/Medical	A. Farita Mana	OWIE KNOWL				-	4b. City. Town, or I	MAY			1:45 A.M.
Examiner		f not institution, give									
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Funeral Director	480-14-1	465 <sup>18</sup>	M 2□ F	e (In yrs. last b	Yrs. Month			(Month, Di	ay, Year)	Country	ce (State or Foreign
death with the Meryland rms 23s or 28s-f show rms the notified at	Usuel Residence of 10a. State	10b. County			vn or Location		· • · · · ·			10d	Inside City Limits
vith the Me to 28e-fe be notified	MARYLAND	MONTGOMER	Υ	SILVER	SPRING						
ith th	10e. Street and Nur	mber				Zip Code			10g. Citizen of W		
23a	13505 SH	ERWOOD FOR	EST TERRA	ACE	20	0904			UNITED S	TATES	
020 urs efter arr, or the	3 □ Widowed	ied 2XXMarried	12. Was Decedent ! Armed Forces?  1 ☑ Yes 2 ☐ If If Yes, Give Year or Dates: [	No	If Yes, sp	edent of l secify Cub 2 □ No	Hispanic Origin? (S ean, Mexican, Puert Specity:	pecify Yes or No o Rican, etc.)		- American c, White, etc	
15-00:	(600)	15. Decedent's Edu	cation		. Decedent's Us		pation during most of wor	kina	16b. Kind of Bus	siness/Indus	stry
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aryland 2 should be filed ad Mental Hygis marked other matic avent, I	17. Father's Name	(First, Middle, Last)					18. Mother's Nen	ne (First, Middle	e, Maiden Surname	)	
ylan buld be Mental arked o	ABRAM H.	KNOWLES					MARY L.	BOWIE			
		ame/Relationship (Ty	pe, Print)	19	b. Mailing Addre	ss (Street	t and Number or Ru	iral Route Numb	per, City or Town, S	State, Zip Co	ode) 2000/c
1 and 2 1 and 2 Heelth a wher tree	GLORIA J	. KNOWLES	- WIFE				D FOREST				
	20a. Method of Disp			20b. Place o	of Disposition (A	lame of	ice)	Date	20c. Location - 0	City or Town	i, Stete
Peges nent of mt. if h		☐Cremetion 3 ☐R 5 ☐ Other (Specify)	emovel from State		INCOLN			5/18/00	BRENTWOO	AM CIC	RVIAND
Baltimo permit. Pege Department of important: If It any injury or office		neral Service License	90	FI. L	-		ess of Facility	0/10/99	DRENTWOO	לעה לעה	KILAND
W FULL	1 /	r)	11				LDI FUNE	RAL HOM	E, INC.		
	from	he disease/or compli rt feilure. List only or	Plus	the death Or							pproximate
Physician /Medical Examiner	Immediate Cause ( disease or condition resulting in death)		META	STAT		EAI	) AND			0	iterval Between Inset end Death
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d be det				4.				040 141-	s en eutopsy	24h Ware	autopsy findings
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The law the has the page 2 s									Λ.	of de	ath?
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of Vital Rec ystelen: The law lis cartificate has to director, page 2 at To Be Compl	25. Wes case reference examiner?						26. Place of Dec	oth (Check only	one)		
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Division o  To the Hospital or Attending Ph Within 24 hours effer death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injubuilding, etc.	iry - At home, f :: (Specify)	erm, street, fect	ory, office		28f. Location ( City or To	(Street and Number own, State)	or Rural F	Route Number,
he Hospit in 24 hour he Funer pletely filli edical		1 Cortifying Phys 2 Medical Examin		examination as							
To withing to the sound of the state of the	29b. Signature and	title of certifier	lande	rth	m)	9c. Licen	se number 3	6	29d. Date signed	(Month, Da	799
	30. Name and addre	ness of pyrison who co	mpleted cause of d	eath (Item 23a)	(Type, Print)	AKKI	PASIN	#13 ALE	45	My	20815
State Registrar	31. Dete filed (Mont		32. Registra	ar's Signature	9. 1	ack	'/	FIVE	chen	CHIS	2000.0



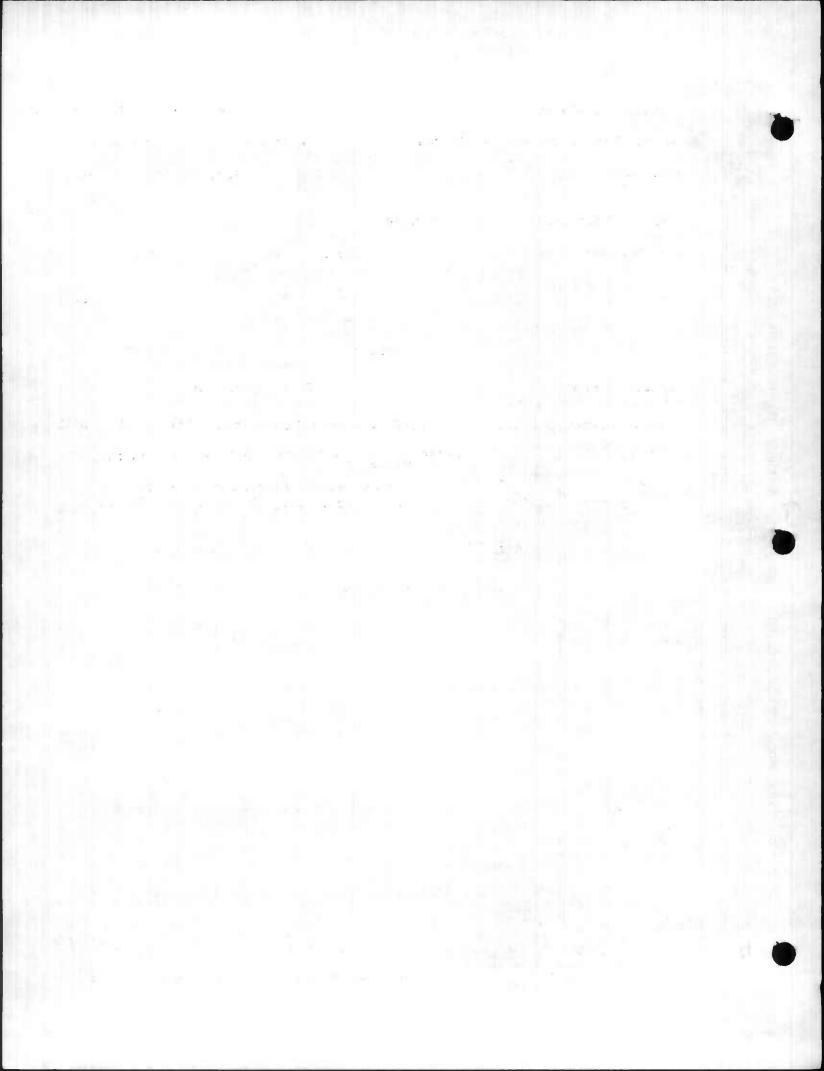
State of Maryland / Department of Health and Mental Hygiene 99 171, 01

				Ce	rtificat	e of	Death			Reg. No.			
61.1.1.	1. Decedent's Nama (First, A	fiddla, Last)							2. Date of D Month	eath Day	Year	3. Time of Death	
Physician Medical	LAURA	V. KOCH							MAY 7,		T Gal	11:58 P.M	
Examiner	4e Facility Name (If not Institute 12814 ROUTE		number)			1	4b. City, To		ocation of Dee		of Death		
Funeral Director	5. Social Security Number 198–10–7273	6. Sex 1 □ M 2 7		yrs. last birthdey Yrs.	If Under Months			24 Hrs. Min.	8. Date of B (Month, D	irth (ay, Year)		place (Steta or Foraign ntry) NNA .	
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tel tygiene. d other than "natural", or tems 23a or 28a-f ahow evant, the Medical Examiner must be notified at Be Completed by Funeral Director	MADVET AND MA										10d. Inside City Limits 1 ☐ Yes 2 No		
r Nems 23a or 28a-fa instrument by northing Funeral Director	10e. Street and Number				10f. Zip				10g. Citizen of	What Cou	intry?		
23a	12814 ROUT					679			U.S.				
ttems marin	11. Marital Status	Armed	Decedent Ever	in U,S. 13.	If Yes, spe	dent of I	Hispanic On oan, Mexicer	igin? (Sp n, Puerto	ecity Yes or N Rican, etc.)		ck, White,		
0 3		rced If Yes,	es 2 No Give or Dates:		1 ☐ Yes	2 No	Specify:			Specif	WHIT	E	
"natural", adical Exp	15. Deci	edent's Education		16e. Dece	edent's Usu	al Occu	pation			16b. Kind of B	usiness/In	ndustry	
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raumatic evant, the M To Be Comp	12	-0-		SE	CRETA	RY				MED	CAL		
vant	17. Father's Name (First, Mic	idia, Last)					18. Mothe	er's Nem	e (First, Middle	a, Ma <i>idan Sum</i> ar	na)		
etic e	HARRY VAND	EGRIFT					M/	MEL1	INE JAM	ISON			
tam 27 is marked other other traumatic evant, To Be C	19a. Informant's Name/Rele									ber, City or Town		p Code)	
r other tr	J. DAVID KOC	H, JK./ SO			IREWO		DRIVE	H(	Dete Dete	PA. 190		our State	
- 1	20e. Method of Disposition 1 ☐ Burial 2 🛣 Cremat		om State	b. Place of Disposition (Nema of cematary, cremetory or other place)  HESAPEAKE CREM. CTR.							on - City or Town, State		
important: I any injury o once.		4 □ Donation 5 □ Other (Spacify)  21. Signeture of Funeral Service Licensee					ess of Facili		5-8-99	CHESTER	R, MD	. 21619	
nysician Medical xaminer	23a. Pert1. Enter the disees shock, or heart failure.  Immediate Cause (Finel disease or condition resulting in death)									arrest,	E	Approximate Interval Between Onset end Deeth	
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bed the Asset	Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause							V					
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should should									24a. Wa	s an autopsy formed?	a	Vere autopsy findings valiable prior to ompletion of cause if death?	
aga 2									10	Yes 2 No		□ Yes 20 No	
E 0 0	25. Was case referred to me	dical					28 Place	e of Deat	h (Check only			2 100 /2 10	
Als cent direct	examiner?	Hospital:	☐ Inpatient	2 ER/Outpatie	ent 3 Do	OA Ot	ther	ursing Ho	~	sidence 6 Ott	her (Spec	ifv)	
fter ti	27. Manner of Death	28a. Da	ate of Injury fonth, Day Yea		-	28c. Inju				how Injury occu		.,,,	
Director Director J in by th		ould not be itermined 28e. Pla	ace of Injury - authorized	At home, farm, soecify)	treet, factor	y, office				(Straat and Num own, Stata)	ber or Rui	ral Routa Number,	
within 24 hours after death.  To the Funeral Director. After the completaly filled in by the funeral Medical Certification:		tifying Physician: To tical Examiner: On the and m											
Vithin To the	29b. Signature and title of ce	rtifier	100	7	29	c. Licen	se number			29d. Date signi	ed (Month	, Day, Year)	
	10.	on /	4	N	10	1	5	35	97	05	08	3 99	
	30. Name and address of per	rson who completed co	euse of death	(Item 23e) (Type	Print)	AI	RATI	- <	ST :	ST M.	CHA	ELS ME	
State	31. Date filed (Month, Day, )	'ear) 32	2. Registrar's S	Signature	6	1						)	
Registrar	MAY	1 0 1999	Jane	va f	7. 1	pa	KN						



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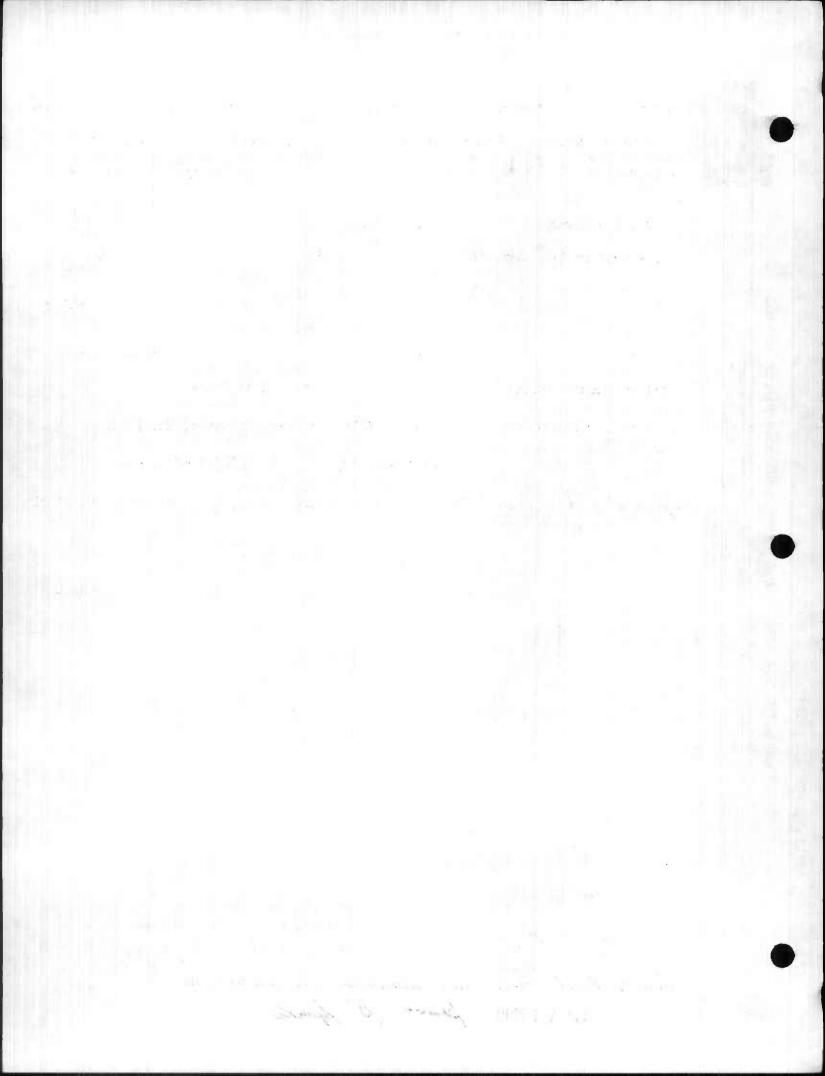
	1. Decedent's Name	(First Middle I a	st)		C	ertifica	ite or	Dealli	2. Date of De	Reg. No.		3. Time of Death
lan									Month	Day	Year	
cal . ner	Jennie 4a Facility Name (II	T. Lipsi not Institution, giv	tz e street and numb	er)				4b. City, Town,	or Location of Deat		999 of Death	8:50 PM
	Hebrew Ho 5. Sociat Security No 578-84-08 Usual Residence of	43 6. S		shingt Age (In yrs. 89	_	Month:	ler 1 Year s Days	Rockvi If Under 24 H Hours M	in. 8. Date of Bir (Month, Da			ace (State or Foreign
	10a. State	10b. County		10c. Ci	ty, Town or	Location					10d. Inside City Li	
Director	MD	Montgome	ry	Roo	ckvill	Le						1 ☐ Yes 2 No
	10e. Street and Nun						Zip Code			10g. Citizen of	What Coun	try?
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	11. Marital Status  1 ☐ Never Merric  3 ☑ Widowed	ed 2 Married	12. Was Decede Armed Force 1  Yes 2 It Yes, Give Year or Date	es? XINo	1,5.	13. Was Decedent of Hispanic Origin? (Spe It Yes, specify Cuban, Mexican, Puerto I 1 ☐ Yes 2 ☒ No Spacity:			(Specify Yes of No erto Rican, etc.)	Bla Specif	ca - America ck, White, e	
	(Snec	15. Decedent's Edify only highest gra	ducation		16a. De	cedent's Us	suel Occup	ation during most of t	working	16b. Kind of B	usiness/Ind	lustry
1	Elementary/Secon		College (1-4	or 5+)	life	. DO NOT	use retire	d)				
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											110)	
1	Albert F		Type, Print)		19h Ma	ailina Addra	ss (Street		pplestein Rural Route Numb		State. Zin	Code)
Hannah Kaufman/Daughter  20e. Method of Disposition  **Topic Method of Disposition										ngton		
	disease or condition resulting in death)  Sequentially list confit eny, leading to imcause. Enter Under Cause (Disease or that infliated events resulting in death) E	nditions, mediate riying injury	b. A J	Due to ( Due to (	or as a cons	RC// saquenca o	1): JOMA f):		COL			
			d									
-	Pert II. Other signifi	cant conditions o	ontributing to deat	h but not res	sulting in the	aunderiying	g cause giv	en in Part I.	23b. Did tobacco use contribute to the			
										an autopsy omed?	ava	ora autopsy tindings tilable prior to impletion of cause death?
1									10	Yes 20 No		Yes 2 No
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1	examiner?	No	Hospital:	atient 2	ER/Outpat	tient 3 🗆 l	DOA Ott	or V	g Home 5□ Res		ner (Specify	1)
	27. Manner of Death 1 Naturel 2 Accident 3 Suicide 4 Homicide	5 Pending investigation 6 Could not be determined	e 28e. Place of	Day Year)		М		yat k? Yes 2□No				l Route Number,
	29a. Certifier (Check only one)			s of examina					aca, and due to tha courred at the time,			
Medical	29b. Signature and	n of continer	Para			2	9c. Licens	18084		29d. Dete sign	ed (Month, I	Day, Year) 999
		16000	(100)	•			S	10-01	OCKVILLE	MAY	1	111



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** may 1015 Margaret Louise Lipsett /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO Hours Min. 8. Dete of Birth (Month, Dey, Year) 01/12/1920 if Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthdey) **Funeral** 1 M 2 F Deys Yrs 79 Director 216-38-9168 Maryland Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Somerset Princess Anne 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 30514 Nutters Lane Apt. 18 21853 USA Funeral Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married 1□ Yes 2 No Specify: à 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within. Degatiment of Health and Mental Hygiene. Important: If fem 27 is mented other than 1 in highly or other trainmatic event, the Men. Elementery/Secondary (0-12) College (1-4or 5+) 8 Clerk Department Store 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) William Hargis Hickman Mary Emma Dykes 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Charles L. Lipsett/Son 10109 Atlantic Road, Atlantic, Va. 23303 20b. Plece of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete Burial 2 Cremetion 3 Removel from Stete 4 □ Donetion 5 □ Other (Specify) Olivet Cemetery 5/17/99 Eden. Md. 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Hinman Funeral Home M00295 11673 Somerset Ave., Princess Anne, Md. 21853 LIKIKAL OX Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Physician/Medical Examiner attending physician and for use es the burial-transit law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or es e consequence of): Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Bullation p 24b. Were autopsy findings available prior to 24e. Wes en autopsy performed? Completed completion of ceuse of death? certificate 1 Yes or Attending Physician: effer death. Director: After this certifica director, 25. Wes cese referred to medical examiner? Be 26. Plece of Deeth (Check only one) 1 ☐ Yes 2 Ø No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 0 1 Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA : After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident To the Hospital or Atter within 24 hours efter dea To the Funeral Director completely filled in by th 6 Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) edical 1 Certifying Phyalclan: To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the cause(s) end menner as stated. 29e. Certifier 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner steted. 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) SALISBUYY, MD HILLIAM RobINS 1104 HEALTH NON 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture 1999 Registrar

Margaret Lipsett



**Physician** 

/Medical

Director

Completed by Funeral

Be

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Physician/Medical Examiner

Be Completed by

Medical Certification: To

Dorothy Elizabeth Lednum

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	Re	gistrar
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					ertificate c			. No.	11111
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DOROT	THY	ELIZABET	Н 1	LEDNU	M		May 7,	199	
e Fecility Name (	(If not institution, g	giva street and num	ber)			4b. City, Town, or	Location of Death	4c. County	of Deeth
		Hospita				Easton		Talb	
. Sociel Security N		. Sex 7 1 □ M 2 1 F	7. Age (In yrs. 7.5	last birthda Yrs.	Months Da			(ear)	Birthplece (Stete or Foreign     Country)     ARYLAND
216-16-6 Isuei Residence o		Λ	-13	113.			001.10,15	23	TAKILAND
0a. Stete	10b. County		10c. Cit	y, Town or	Location				10d. tnslda City Limits
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0e. Street end Nu	ımber				10f. Zip Cod	е	10g	. Citizan of V	/hat Country?
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1000	riad 2 Married		2 <b>X</b> XV0		1 ☐ Yes 2 ☐X		10 11,0011, 410.7	Specify	UNITER
3 Widowed		Year or De							
(Spe	15. Decedent's cify only highest	Education grade completed)		(Gi	cedent's Usuel Oc ve kind of work do b. DO NOT use re	ne during most of wo	orking 16	b. Kind of Bu	siness/Industry
Elamentery/Second 12	ondary (0-12)	Collega (1-	4or 5+)		OMEMAKER	11007		OWN	HOME
7. Fether's Neme	(First, Middle, La			1	OTTEL HARLETT	18. Mother's Ne	me (First, Middle, Ma	iden Sumam	θ)
ROY C.	HUMMER					HELEN	F. HASHAG	EN	
19a. Informent's N	leme/Reletionship	(Type, Print)					ural Routa Number, C		
HELEN L	. ROUSE/	DAUGHTER	t	6235	CHURCH	HOME ROAD	, RHODESDA	LE, MD	21659
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29a. Certifiar (Check or one) 29b. Signature end title of confiner

29c. Licensa number D41723

29d. Date signed (Month, Dey, Year)

MAY 8, 1999

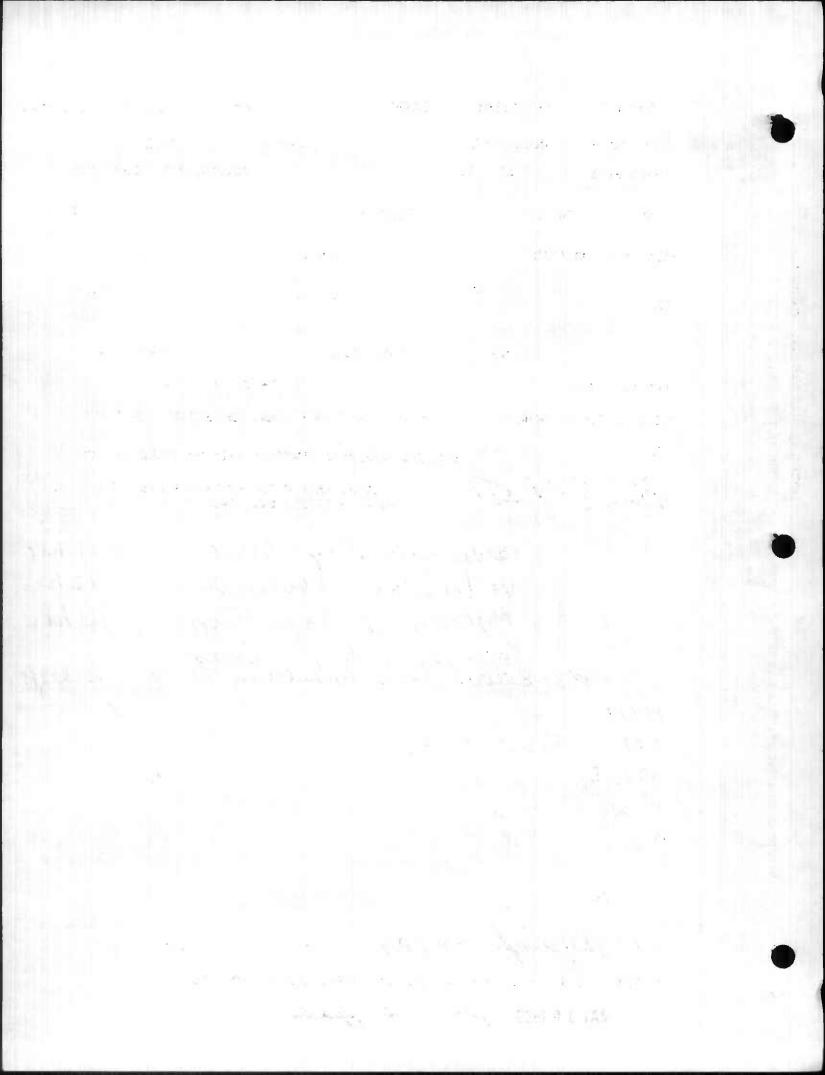
30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

DR. CHRISTADOSS RAJASINGH, 403 MARVEL COURT, EASTON, MD 21601

31. Dete filed (Month, Day, Year) MAY 1 0 1999

32. Registrar's Signeture

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death 16 1999 1999 1999 **Physician** May Robert. George MATESA 07:00am /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Neme (If not institution, give street and number) Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** Deys 1(XM 2□ F 75 Yrs. **Director** 178-12-4766 August 21 Pennsylvania Usuel Residence of Decedent 1923 the Meryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show Pennsylvania Allegheny Pittsburgh 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours efter death with nent of Heelih and Mental hygiene. In the file the 23a or one: if it fem 27 is marked other than "natural", or items 23a or iny or other traumatic avant, its Mod at Earning manual. 15203 2840 Berg Street USA Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. ne Yes 2 No Jan. 23 r Yes, Give 1943 Year or Detes: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White P 3 ☐ Widowed 4 ☐ Divorced to Mar. 27, Completed Decedent's Usuel Occupetion
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Production Worker 10th 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be Rocco Matesa Anne Ruzic 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mary Matesa (Wife) 2840 Berg St., Pittsburgh, Pa. 15203 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition ABuriel 2 □ Cremetion X Removel from Stete 4 □ Donetion 5 □ Other (Specify) May 20 Depertment of Important: If any injury or Pittsburgh, Pa. Loretto Cemetery 1999 21. Signature of Funerel Service Licensee M - 0084922. Name end Address of Fecility Paul T. Lochstampfor Lochstampfor Funeral Home, Inc.

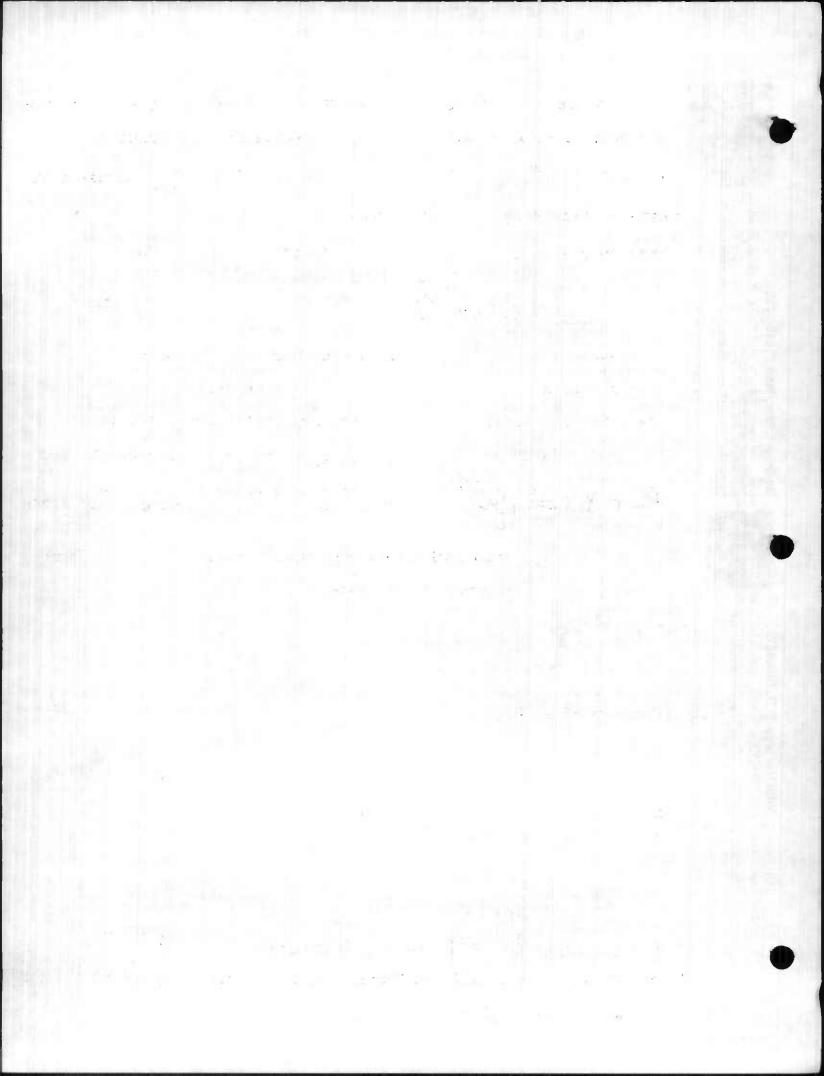
48 S. Church St., Waynesboro, Pa.

23e. Perl: Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Inc.

Applications for the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Inc.

Applications for the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Inc. 17268 Approximete Interval Between Onset and Deeth **Physician** Immediete Cause (Finel diseese or condition resulting in deeth) /Medicai Arteriosclerotic Cardiovascular Disease Years Examiner Due to (or es e consequence of): Examiner Coronary Artery Disease physician end the burial-transit that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting In deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of) 88 USB signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 🗵 Unknown Carcinoma of the lung à 24b. Were autopsy findings eveilable prior to 24a. Was an autopsy performed? Completed completion of cause of deeth? page 2 hes 1 ☐ Yes 2 No certificete 1 ☐ Yes 2 ☐ No Attending Physician: director. 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 70 1 XYes 2 No After this funeral 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Neturel 5 Pending investigation Hospital or Attendin 24 hours after death.
 Funeral Diractor: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined To the Hospital or Atte within 24 hours after de To the Funeral Diracto completely filled in by the 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and menner es stated.

Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete and piece, and due to the cause(s) and manner stated. 29e. Certifie edical 29d. Date signed (Month, Dey, Year) May 16, 1999 29b. Signature and title of certifier 29c. License number D3516 30. Name and address of person who completed caute of deeth (Item 23e) (Type, Print)
Andrew Zarick, Jr., MD., 1080 West Patrick Street, Frederick, Maryland 21703 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State MAY 17 1999 Dark Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) Day 1999 **Physician** May 12, Clifton Mabry 8:30 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 12127 Selfridge Road Wheaton Montgomery 6. Sax 1 → M 2 □ F If Under 1 Year | If Undar 24 Hrs. 8. Date of Birth (Month, Day, Yaar) OCt. 19, 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 7. Aga (In yrs. last birthday) Months Days Hours 1920 78 Yrs. 227-18-2139 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√ Yas 2 No Director Montgomery Wheaton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12127 Selfridge Road 20906 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces?
12 Yes 2 □ No If Yas, Give Yeer or Dates: WW Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American indian. 11. Marital Status 1 Nevar Married 2 Married 1 Yes 2 No Specify. White þ WWII 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education permit. Pages 1 and 2 should be fised within 72. Department of Health and Mental Hygieno. Irreportant: if flem 27 is marked other than "national plays or other traumstic event, the Medica 0058. (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 18. Mother's Name (First, Middle, Malden Surnama) 17. Fether's Name (First, Middle, Last) Wesley Hayse Mabry Catherine Mullins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Catherine M. Mabry (Wife) 6321 Jackson River Rd. Hot Springs, VA 24445 20b. Place of Disposition (Name of cematary, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from Stete 5/15/99 Hylton Cemetery Covington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Sarvice Licensae 22. Nama and Address of Facility Arritt Funeral Home, Inc. 1102 S. Highland Ave. Covington, VA Part 1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediete Ceuse (Final Severe COPD - End Stage Pulmonary Disease disaase or condition resulting in death) Due to (or es e consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequenca of) Physician/Medical that initiated events rasulting in daath) Last Dua to (or as a consaquence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause givan in Part I. 23b. Did tobacco usa contributs to the cause of death? HBP, Arrhythmia, Malnutrition 1X Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to 24e. Was an autopsy Completed completion of cause of deeth? 1☐ Yes 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5XXResidenca 6 Other (Specify) 1 ☐ Yes 2 No To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) Certification: 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 4 Homicide edical 29a. Certifier cartifying Physician: To the best of my knowledge, daath occurred at the time, date and place, and due to the cause(s) and manner as stated. medical Examiner: On the besis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and pieca, and due to the cause(s) end manner steted. nature and titing cartifier 29b. 29c. Licansa number 29d. Data signed (Month, Day, Year) 010 ana and address of person who completed cause of deeth (ttem 23e) (Type, Print) John Saia, M.D. 809 Veirs Mill Rd. #101 Rockville, MD

State Registra 31. Date filed (Month, Day, Year) MAY 18 1999

32. Registrar's Signature

Director

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72 hours after

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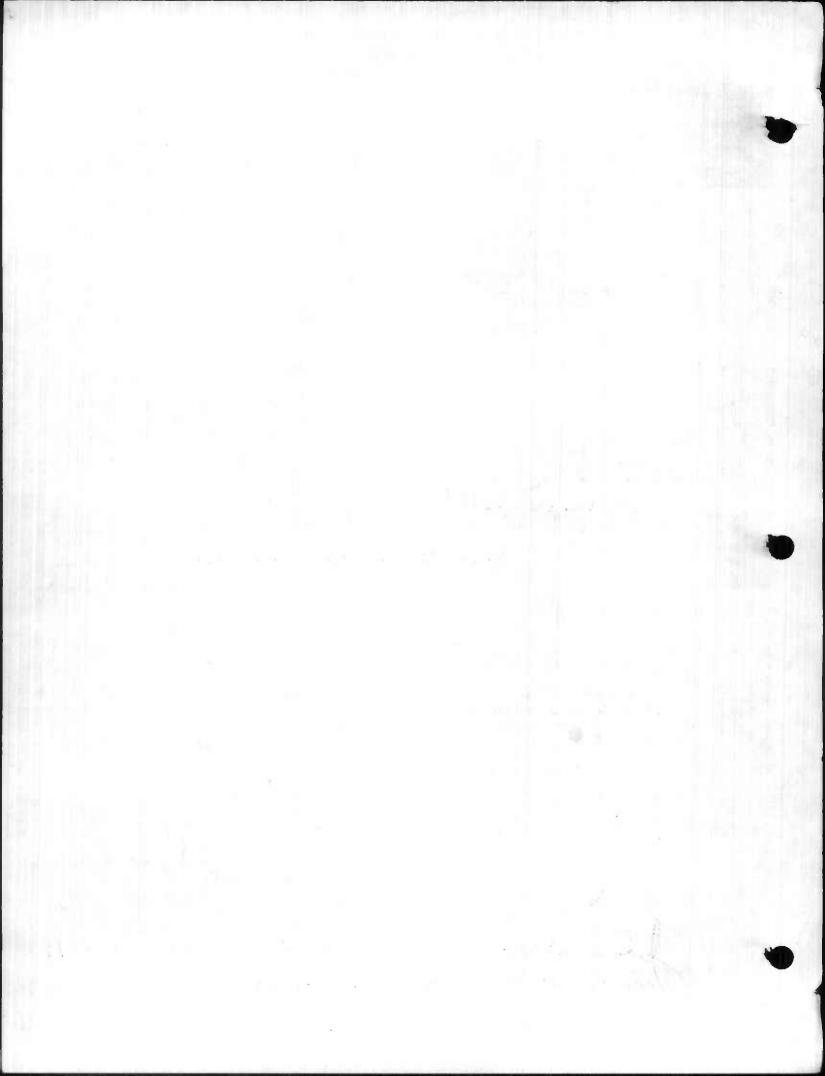
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Division of Vital Records,



State of Maryland / Department of Health and Mental Hygiene

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30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) 2101 metric of Part Dr JRB N. BRECHER, MO DME 9, IVEX Spring, MC 20902  State  31. Date filed (Month, Dey, Year)  32. Registrar's Signature				Ida misa	10 Kinn	0 0	ME	1	200	428	1					
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